

# ICAN

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Report Compiled From 1999 Data

## **CHILD DEATH REVIEW TEAM REPORT FOR 2000**

*Photographs were selected from commercially available sources and are not of children in the child protective services system. Children's names in case examples have been changed to ensure confidentiality.*



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# TABLE OF CONTENTS

Foreword .....	v
ICAN Child Death Review Team Members .....	ix
ICAN Organizational Summary .....	xi
ICAN Child Death Review Team Training and National Center on Child Fatality Review .....	xvii
Introduction .....	1
Findings .....	3
Recommendations .....	9
Team Protocols for Case Referral .....	15
Child Homicide by Parents / Caretakers / Family Members .....	21
Enrique and Marisela .....	21
Cassie .....	32
Baby Girl Doe .....	38
Aaron .....	47
Accidental Child Deaths .....	49
Shirley .....	49
Undetermined Child Deaths .....	61
Melinda .....	61
Adolescent Suicides .....	67
Raymond, Andrew, Serena, Janelle, Danny, Ronald .....	67
Fetal Deaths .....	79
Diana .....	79
"How To" Guide for Child Fatality Review Teams .....	85
Introduction .....	85
"How To" Guide .....	87

*Names of all children used in case study examples have been changed.*

## FOREWORD

A toddler dies with head trauma after being left with mom's violent boyfriend. An apparent SIDS is found at autopsy to have subdural and retinal hemorrhages. A toddler dies suddenly at childcare from head trauma. These whodunits are well managed by ICAN Child Fatality Review. The ICAN Child Death Review after 600+ reviews of homicide by caretaker has unique competence. Additional resources are necessary to develop competence with all forms of child death including motor vehicle deaths, suicides and coroner's fetal deaths.

About 2,000 children die each year in this county with 200 hundred referred to the ICAN team for consideration. Homicides by caretaker number 40+ in most years, with formal review of 3 to 4 cases a month. Attempts to expand resources by dividing the county into additional teams have failed, but efforts to create special teams and special resources have made progress.

The LA County Office of Education and Department of Mental Health have provided a foundation to address suicide. The Department of Health Services has provided technical resources to develop systems to collect data on all child deaths.

The planned suicide review would consider 20 to 30 cases a year. Previous data on these deaths have included an apparent high rate of previous records for child abuse/neglect and for juvenile delinquency. This unique data defines additional risk factors. Previous professional contacts with children lost to suicide provide a resource

for prevention and early intervention for the next child.

Computer and data systems can provide a structure to address all deaths, if only on paper, with demographic data, rates and increased awareness from notices to the agencies with previous contacts. The ICAN Child Death Review needs systematic data collection to participate in an expanding statewide system for standardized data collection on suspicious child death. This same system based on all deaths from all causes will provide a logical structure to expand efforts at prevention and intervention.

Systematic automated collection of case materials will provide material for additional review including child pedestrian and passenger motor vehicle deaths and coroner fetal deaths. All child fatality review provides a focal point to address multiagency intervention and prevention for non-fatal injuries. Responsible case management and learning from success and failure honors the short lives of these children. 🙏

Michael Durfee, M.D.



## ICAN CHILD DEATH REVIEW TEAM MEMBERS - 1999

**Michael Durfee, M.D.**

Department of Health Services,  
Co-Chair

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District Attorney's Office,  
Family Violence Division  
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**Gerry Moland**

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**Jeanene Morimoto**

LAC/USC Medical Center



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## INTER-AGENCY COUNCIL ON CHILD ABUSE AND NEGLECT (ICAN)

The Inter-Agency Council on Child Abuse and Neglect (ICAN) was established in 1977 by the Los Angeles County Board of Supervisors. ICAN serves as the official County agent to coordinate development of services for the prevention, identification and treatment of child abuse and neglect. It is the largest county-based child abuse and neglect network in the nation.

Twenty-seven County, City, State and Federal agency heads are members of the ICAN Policy Committee, along with UCLA, five private sector members appointed by the Board of Supervisors and the Children's Planning Council. ICAN's Policy Committee is comprised of the heads of each of the member agencies. ICAN's activities are carried out through a variety of committees comprised of both public and private sector professionals with expertise in child abuse. These committees address critical issues affecting the well-being of the most vulnerable children including prenatally substance affected infants, pregnant and parenting adolescent, children exposed to family violence, abducted children, and siblings of

children who are victims of fatal abuse. Fifteen community based inter-disciplinary child abuse councils interface with ICAN and provide valuable information to ICAN regarding many child abuse related issues. ICAN provides advice and guidance on public policy development and program implementation to improve the community's collective ability to meet the needs of abused and at-risk children with the limited resources available. ICAN Associates is a private non-profit corporation of volunteer business and community members who raise funds and public awareness for programs and issues identified by ICAN.

In 1996, ICAN was designated as the National Center for Child Fatality Review. ICAN has also received national recognition as a model for inter-agency coordination for the protection of children.

All ICAN Policy and Operations Committee meetings are open to the public. All interested professionals and community volunteers are encouraged to attend and participate.

*For further information contact:*

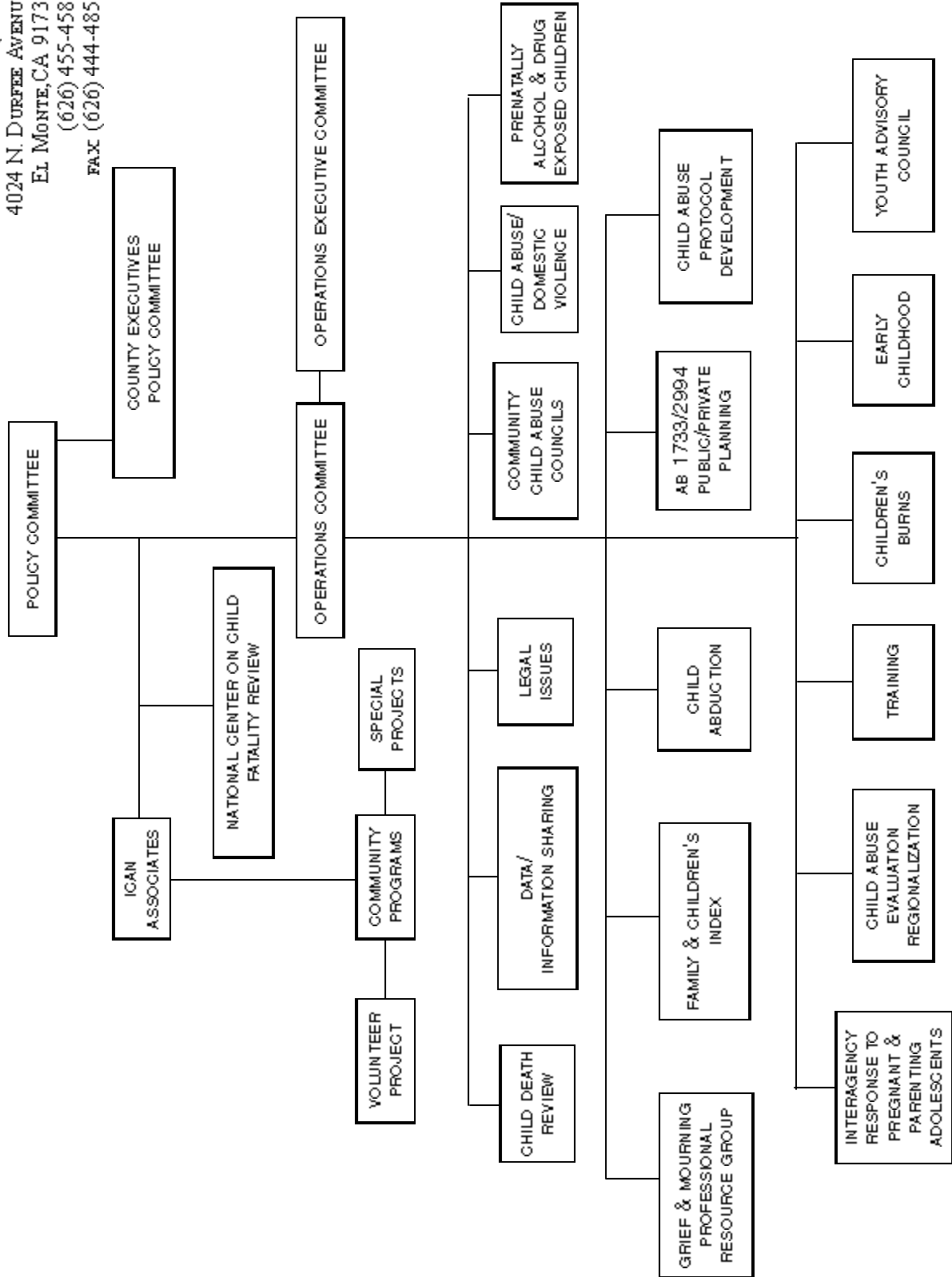
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**CHILD ABUSE/DOMESTIC VIOLENCE**

Examines the relationship between child abuse and domestic violence; develops interdisciplinary protocols and training for professionals. Provides training regarding issues of family violence, including mandatory reporting. Sponsors annual conference "Nexus". (Meets as needed for planning of NEXUS Conference)

**PRENATALLY ALCOHOL/DRUG EXPOSED CHILDREN**

Works to improve the system rendering services to drug/alcohol exposed children and their families. Provides training on evaluating needs of prenatally substance exposed infants and their families; assists in developing and identifying resources to serve drug impacted families. (Meets every 2nd Tues., 10:00 a.m., White Memorial Medical Center, L.A.)

**GRIEF AND MOURNING PROFESSIONAL RESOURCE GROUP**

A professional peer group which serves as a resource pool of experts in grief and loss therapy to those providing mental health interventions to surviving family members of fatal family violence. The Group is developing specialized training in grief issues in instances of fatal family violence and a resource directory of services. (Meets every 2nd Wed., 9:30 a.m.)

**FAMILY AND CHILDREN'S INDEX**

Development and implementation of an interagency database to allow agencies access to information on whether other agencies had relevant previous contact with a child or family in order to form multidisciplinary personnel teams to assure service needs are met or to intervene before a child is seriously or fatally injured. (Meets as needed)

**CHILD ABDUCTION/REUNIFICATION**

Public/private partnership to respond to needs of children who have experienced abduction. Provides coordinated multi-agency response to recovery and reunification of abducted children, including crisis intervention and mental health services. (Meets every 3rd Wed. at 12:30 p.m., Find the Children, 3030 Nebraska Avenue, Santa Monica) Note: This is a closed meeting.

**AB 1733/AB 2994 PLANNING**

Conducts needs assessment and develops funding guidelines and priorities for child abuse services; participates in RFP process and develops recommendations for funding of agencies. (Meets as needed)

**CHILD ABUSE PROTOCOL DEVELOPMENT**

Develop a countywide protocol for inter-agency response to suspected child abuse and neglect. (Meets monthly, no set day)

**INTERAGENCY RESPONSE TO PREGNANT AND PARENTING ADOLESCENTS**

Focuses on review of ICAN agencies' policies, guidelines and protocols that relate to pregnant and parenting adolescents and the development of strategies which provide for more effective prevention and intervention programs with this high-risk population. Includes focus on child abuse issues related to pregnant teens, prevention of teen pregnancies, placement options for teen mothers and babies, data collection, legal issues and public policy development. (Meets every last Wed. of the month, 12:15 p.m., Ed Edelman Children's Court)



## **CALIFORNIA CHILD DEATH REVIEW TEAM TRAINING & THE NATIONAL CENTER ON CHILD FATALITY REVIEW**

For more than 20 years, ICAN has been in the forefront of efforts to identify, evaluate and prevent child abuse and neglect-related fatalities. The ICAN Child Death Review Team, established in 1978, has become a model of inter-agency collaboration around the issue of analysis of child death resulting from abuse or neglect. ICAN's efforts in this area have garnered attention and support both at the state and national levels, resulting in grants to develop statewide Child Death Review Team Training, as well as grants establishing ICAN as the National Center on Child Fatality Review.

Based upon grants from the California Office of Criminal Justice Planning and the Office of Child Abuse Prevention, ICAN developed and implemented Child Death Review Team Training during 1998 and 1999. The two day training curricula, presented in Los Angeles, Fresno, Emeryville, Sacramento, Redding and San Diego Counties (additional training is planned for Palm Springs and South Lake Tahoe during 2000) used multi-disciplinary presentations, mock case reviews, database development information and a technology presentation to further develop and enhance the skills of the hundreds of professionals who attended the trainings. The training format itself modeled the inter-agency collaboration necessary to conduct effective and useful reviews of child abuse-related fatalities. The San Diego training was unique in the history of child fatality review activities in that more than twenty professionals from various dis-

ciplines in Mexico attended, offering a unique, international perspective. Further, the issue of child abduction and international law regarding retrieval of children illegally taken from the U.S. to Mexico was included in the San Diego training, as children have been abducted from the U.S. and subsequently killed while in Mexico.

Beginning in 1996, ICAN was designated by the U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, and the U.S. Department of Health and Human Services as the National Center on Child Fatality Review (NCFR). The NCFR provides a source of information exchange and development of services for professionals involved in the field of child fatality review throughout the United States. Further, the NCFR web site located at [ICAN-NCFR.org](http://ICAN-NCFR.org) provides a central point of information sharing among national and international professionals in the field. The NCFR, with the invaluable assistance of principal consultant Michael Durfee, M.D., has developed a database of child fatality review professional liaisons in all fifty states, international contacts and national and federal agency contacts. These contacts can be accessed through a searchable directory on the ICAN-NCFR web site. In addition, the NCFR web site has expanded its links to other child death review and child welfare web sites on the internet, has posted national and state data sets regarding child deaths, and in March 2000 produced a nationally televised satellite child death

## INTRODUCTION

For most of us, children evoke a sense of hope, optimism, innocence, wonder, and, most of all, love. They represent the chance that we all want to make things right. When children die, the sense of loss is profound, and curiously personal even in those instances where we did not know the child.

ICAN's Child Death Review Team meets monthly to review deaths of children in our county. Usually these children are very young, under the age of three. Often, these infants and toddlers have been intentionally killed by a parent or caretaker or have died as the result of severe abuse or neglect. The circumstances of their deaths are sometimes shocking, often maddening, and always frustrating and poignant.

Through an in-depth review involving professionals from health services, child protective services, law enforcement, district attorney, coroner's office, dependency court, schools, and others, the team attempts to reconstruct events that led up to the child's death, examine the family's life prior to the child's death, and determine whether the death could have been prevented, and, if so, what interventions might have saved the child's life.

This tenth annual report of the ICAN Multi-Agency Child Death Review Team provides information on children's deaths that occurred in 1998. It provides a detailed analysis of child abuse and neglect related fatalities, and data on accidental, natural and fetal deaths, as well as suicides. Importantly, the report also provides recommendations that we hope, when implemented, will save children's lives. Saving those lives is the ultimate goal of our work. 🙏



## FINDINGS

### **CHILD HOMICIDES BY PARENTS / CARETAKERS / FAMILY MEMBERS**

- 49 child homicides by parents/caretakers/family members were identified by the Team in 1998. This is an increase of 9% over the 45 child homicides by parents, caretakers or family members identified in 1997, and consistent with the previous 10 year average of 47.
- 55% (n=27) of the victims were female in 1998, 45% (n=22) of the victims were male. Over the past 10 years, there have been a total of 255 male victims (54%) and 216 female victims (46%).
- 33% (n=16) of victims were under the age of 6 months. 43% (n=21) were under the age of 1 year. 59% (n=29) were age 2 or younger. Over the past 10 years, 43% (n=203) of the victims have been under the age of 1 year, 85% (n=400) have been under the age of 5 years.
- 57% (n=28) of victims were Hispanic. 22% (n=11) of the victims were African American. 16% (n=8) of the victims were white and 2% (n=1) of the victims were Asian. The Coroner was unable to determine the ethnicity of 1 of the victims.
- 26.5% (n=13) of the fatal injuries were a result of head injuries caused by blunt force cerebral trauma, shaken baby syndrome or a combination of both.
- 63% (n=31) of the fatal injuries were caused by direct assault, the perpetrator using no weapon other than their own hands.
- Deaths due to gunshots were the second leading cause of child homicide by parents/caretakers/family members, comprising 20.4% (n=10) of the cases. In the past, deaths due to gunshots were the third leading cause of these deaths.
- The deceased child had siblings identified in 53% (n=26) of the cases.
- 53% (n=26) of the families had a history of receiving public assistance from the Department of Public Social Services. Between 1989 and 1997, the percentage of families with prior public assistance ranged from 49.2% to 62.5%.
- 41% (n=20) of the families had a current or prior record of referral of children to child protective services prior to the death of the child.
- 8% (n=4) of the child homicide by parents/caretakers/family members victims had medical records at Los Angeles County Department of Health Services facilities. No comparison with prior years can be made as the method used to obtain these clearances is being updated and clearances could not be obtained for all of the 1998 cases.

in 1998 and represented 40% (n=38) of the total number of accidental child deaths. Deaths associated with maternal substance abuse were also the leading cause of accidental child death in 1996, the only other time when drowning was not the leading cause.

- The number of accidental child deaths due to drowning decreased 33% (n=21) from the 28 deaths due to drowning in 1997. Deaths due to drowning were the second leading cause of accidental child death in 1998.
- Autopedestrian deaths - deaths resulting from children being hit by cars were the third leading cause of accidental child death in 1998. There were 19 autopedestrian deaths, representing 20% of the total accidental child deaths in 1998. This number is a 138% increase over the 8 such deaths in 1997. However, it is unclear if this number represents an actual increase in the numbers of these deaths or rather, better identification of these deaths by the Team.
- 67% (n=64) of accidental child death victims were male, 33% (n=31) were female.
- 41% (n=39) of the accidental child deaths occurred in victims under the age of one year.
- 44% (n=42) of the accidental child death victims were Hispanic children. Hispanic children comprise 48.2% of the county child population.
- White children represented 21% (n=20) of the accidental child death victims. White children comprise 27.9% of the

county child population.

- 32% (n=30) of the fatal accident victims were African American, compared to 12.3% of the county child population.
- 48% (n=46) of families had a history of receiving public assistance from the Department of Public Social Services.
- 23% (n=22) of the families had a record of receiving child protective services prior to the death of the child. 50% (n=11) of these cases involved families where the Coroner indicated that the death was associated with maternal substance abuse.
- The deceased child had identified siblings in 29% (n=28) of the cases.
- 16% (n=15) of the victims had medical records at Los Angeles County Department of Health Services facilities.
- 4 cases were presented by law enforcement to the District Attorney. One of these case presentations resulted in criminal charges being filed.

### **UNDETERMINED CHILD DEATHS**

- 28 Undetermined deaths were referred to the Team by the Coroner for 1998. This number represents the highest number of undetermined child deaths since ICAN began collecting this data.
- 71% (n=20) of the undetermined child deaths were of infants under 1 year of age. In the period of 1989 through 1998, an average of 69.7% of the undetermined child death victims have been under the age of 1 year.



## FINDINGS & RECOMMENDATIONS

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- In 89% (n=34) of the fetal accidental deaths, there was a history of maternal drug abuse present.
- There were two fetal homicides reported to the Team for 1998.
- Six of the families who suffered fetal deaths had a record of prior involvement with the Department of Children and Family Services.
- 26% (n=10) of the fetal death families had a history of receiving public assistance from DPSS.
- Three of the fetal death families had a medical record at Los Angeles County Department of Health Services facilities.
- The District Attorney filed criminal charges on one of the fetal death homicides. On two additional cases, charges are pending.

## RECOMMENDATIONS

### **RECOMMENDATION ONE: TIMELY AND DETAILED REPORTING OF CHILD DEATHS**

DCFS and all ICAN agencies should report all known child deaths possibly related to child abuse and/or neglect to ICAN within 24 hours, or as soon as practically possible, of the agencies' awareness of the death. Further, the report to ICAN should include, at a minimum, the child's name, age, date of birth, date of death, and agency investigation/referral number.

**Rationale:**

Note: Recommendation Ten from the 1997 Child Death Review Team Report requested that DCFS and all ICAN agencies report child abuse/neglect-related deaths to ICAN within 24 hours.

Although there have been improvements in reporting of child deaths to ICAN, information provided is often insufficient to allow for timely review of child abuse-related deaths. In order to conduct timely reviews- which can aid criminal investigation and prosecution, improve case management and agencies' policies and procedures, highlight the need for prevention efforts, and produce additional benefits- DCFS and ICAN agencies must provide the identifying information requested as soon as possible.

### **RECOMMENDATION TWO: REPORTING AND COLLECTION OF DATA REGARDING CHILD ABUSE DEATHS**

It is recommended that the Department of Children and Family Services and Department of Coroner report back at the November 2000 meeting of the Policy Committee: 1) the number of child deaths suspected to have been related to child abuse and/or neglect between January 1, 2000 and June 30, 2000; and 2) the number of child abuse/neglect - related deaths entered into the CWS/CMS system.

**Rationale:**

A recommendation for the above action for the time period January 1 to March 31, 2000 was a unanimously approved Action Item from the November 1999 meeting of the Policy Committee. The Action Item, requested to assess compliance with a key requirement of SB 525- the entry of child abuse/neglect - related deaths into CWS/CMS- has not yet been implemented. Management changes and integration of new information systems have impacted the agencies' ability to complete the requested action by the April 2000 meeting of the Policy Committee. The proposed review of child death entries in CWS/CMS is necessary and important to identify barriers to accurate and timely entry of child death data in CWS/CMS.

vene a regular meeting to review youth suicides. The beginnings of such a team, tentatively named the Child and Adolescent Suicide Study Group, is in development, spearheaded by the Los Angeles County Office of Education and Department of Mental Health. The Policy Committee should support the development and growth of this emerging multi-disciplinary team.

**RECOMMENDATION SIX: MOTOR VEHICLE CHILD DEATH REVIEW**

LASD, LAPD, Health Services, County and City of Los Angeles Fire Departments, Office of Coroner, and other agencies as determined by this core group of agencies, should develop a special review team which looks into the motor vehicle deaths of children.

**Rationale:**

Given the population of Los Angeles County, the Child Death Review Team must by protocol limit its reviews to child deaths under age twelve, and primarily homicides by caregivers. The Team has become aware of a disturbing number of child deaths related to both passenger and pedestrian related incidents. A significant percentage of those cases appear to be preventable. Further, the annual report of the Child Death Review Team addresses only children hit by vehicles, not those that die in motor vehicle accidents. A separate team, comprised of professionals who deal with such deaths regularly, should be formed to address this group of child-victims.

**RECOMMENDATION SEVEN: INTER-COUNTY COORDINATION OF CHILD DEATH REVIEW TEAMS**

The California Department of Social Services and Office of the Attorney General should encourage county child death review teams to cooperate in sharing of information when more than one county has had jurisdiction in cases of child death in compliance with SB 644 (Polanco), which became state law in 1997.

**Rationale:**

Child death review is, by definition, a multi-agency process. Frequently, agencies in counties other than the county where the death occurred had significant contact with the child and family prior to the death. Sharing of information is critical to providing services to the family, assisting in pending prosecution or adjudication of criminal and/or dependency court proceedings, and improved management of inter-county child death cases.

**RECOMMENDATION TEN: CHILD ABANDONMENT**

The ICAN Policy Committee should support SB1368 (Brulte) and AB 1764 (Maddox), which would allow mothers/caregivers to take their newborn children to designated persons/facilities for relinquishment within the newborn's first 30 days of life without fear of prosecution for abandonment.

**Rationale:**

The tragedy of mothers abandoning newborns to die is a national issue. Legislation offering mothers of newborns the option of leaving the infant at designated facilities within the first 30 days of life without fear of prosecution has passed or is pending in many states. The Los Angeles County Child Death Review Team has reviewed such deaths, and the Coroner's Office reports that numerous formerly healthy newborns are later found dead in landfills, dumpsters, and along roadways in the county each year. Given the high number of couples wishing to adopt infants, active support of this bill and its eventual passage would help to save lives, provide a positive option for unwanted pregnancies, and allow more couples to provide healthy and loving homes for otherwise unwanted children. 🐦

## TEAM PROTOCOLS FOR CASE REFERRAL

California law requires that all suspicious or violent deaths and those deaths where the decedent was not seen by a physician in the 20 days prior to the death are to be reported to the Department of Coroner. The Coroner is then responsible for determining the circumstances, manner and cause of these deaths.

Every morning, the Coroner's on-duty Supervisor compiles a list of all cases that came to the Coroner's attention during the previous 24 hours. From this compilation, the Coroner has agreed to derive a new list of all children age twelve (12) and under\* where one or more of the following factors are present, for review and study by the ICAN Child Death Review Team:

1. Drug ingestion
2. Cause of death undetermined after investigation by Coroner
3. Head trauma (subdurals, subarachnoid, subgaleal)
4. Malnutrition/neglect/failure to thrive
5. Drownings
6. Suffocation/asphyxia
7. Fractures
8. Blunt force trauma
9. Homicide/child abuse/neglect
10. Burns/smoke inhalation
11. Sexual abuse
12. Gunshot wounds
13. Special populations - fetal deaths and suicides are part of separate studies

*\*Age exceptions are made for apparent suicides, homicides (child abuse) by family member or caregiver and deaths due to drowning.*

Once a case is identified by the Coroner, case specific information is sent to the ICAN offices, where it is routed to Team representatives from the District Attorney's Office, Department of Children and Family Services, Los Angeles Police Department, Los Angeles Sheriff's Department, and Department of Health Services.

Members check each case in their agencies' computers and files for previous contacts with the child or family. Record check findings are then returned to the ICAN office for compilation and analysis.

Selecting cases for comprehensive review by the Team is a process that takes place within the Team itself. Three to five cases that meet the above mentioned criteria are reviewed in depth at each month's meeting. Primarily, high profile cases and cases in which a committee member requests the Team's multidisciplinary perspective, are reviewed by the Team. The Team encourages agency staff involved with the cases to attend the meeting at which that case is discussed to share their observations and findings.

At the end of the year, the Coroner reports summary statistics on all cases reported to the Team to the ICAN Data Information Sharing Committee for its report, The State of Child Abuse in Los Angeles County. This report ( ICAN Child Death Review Team Report) expands upon the Coroner's findings by including the results of the record searches of the other member agencies and additional analysis

- **Fetal** deaths are also handled as a special population. They are not reported with other child abuse or suspicious deaths and are reported separately in a special section of the report. They include fetal homicide cases that are a result of violence against the mother.

The gaps between the Coroner's classifications of child deaths and the public's perception of child abuse fatalities create a dilemma with regard to reporting the Team's findings.

The Child Death Review Team's purpose is to work to prevent or minimize child deaths. In order to do so, the Team must work together to confront patterns of preventable child death within the County through coordinated research and analysis of the root causes of these deaths.

*It should be noted that the Team is currently working with the Los Angeles County Coroner's office to make changes in the protocol of cases to be reviewed and to overhaul the intake system for determining which cases fit the protocol and should be reviewed and included in this report. Cross checks with law enforcement and other state indices (please see the case conciliation process described in the beginning of the homicide section of this report) indicate that a number of cases were missed. Additionally, the Team became aware of a number of cases with Los Angeles County agency involvement that were not Los Angeles County Coroner cases. Aside from one case where the autopsy was done in Mexico, those cases are not included in this report. A determination as to how to address these non-Los Angeles County Coroner cases will need to be made. The hope is to expand the protocol to include more types of cases, improve the system so that children are not missed and assure the protocol remains manageable given the large population of Los Angeles County. It is clear from the problems that were encountered this year that the planned overhaul of our protocol and intake system is much needed and, when completed, should help to ensure the accuracy of the data presented in this report. ☹*

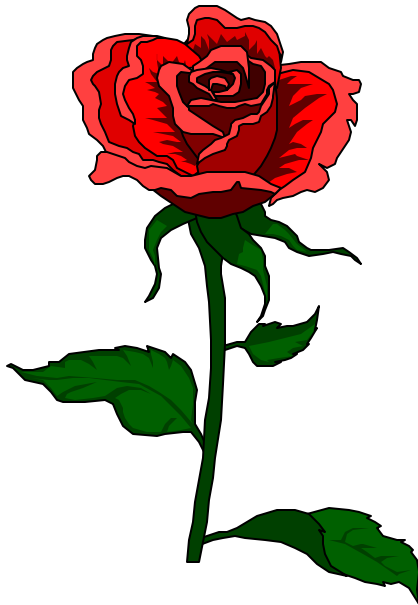
### **CORONER REFERRALS TO ICAN CHILD DEATH REVIEW TEAM - 1998**

197 deaths were reported by the Department of Coroner to the ICAN Child Death Review Team in 1998.

Preliminary review of homicides and reconciliation of the deaths referred by the Coroner to the Team resulted in the removal of 10 out of the 59 homicides that were originally referred to the Team. Of these ten cases, eight involved gunshots, including at least three gang-related shootings, one of which involved a retaliation shooting and one of which involved an exchange of gunfire between 2 rival gangs. In four of the shooting cases, no suspect has been identified. There was also one child killed in an arson fire and one child who was strangled.

In addition to the 59 homicides (49 by parent/caretaker/family member), 95 accidental deaths, 15 adolescent suicides, and 28 undetermined deaths were referred to the Team. No natural deaths were referred to the Team in 1998.

Figure 1 on the next page summarizes how the 197 deaths referred by the Coroner in 1998 were categorized and where adjustments were made.



*In the little world in which children have their existence,  
Whosoever brings them up,  
There is nothing so finely preserved and so finely felt as injustice.*

*Charles Dickens  
Great Expectations*

## CHILD HOMICIDES BY PARENTS/CARETAKERS/ FAMILY MEMBERS IN LOS ANGELES COUNTY

Deputies of the Los Angeles County Sheriff's Department were conducting a follow-up investigation of an earlier pursuit when they noticed a car parked at the side of the road in a forested area of the county. As they stopped to check on the vehicle, a man and a boy emerged from the forest, the boy's hands covered with mud. Deputies investigated further and found two other children and an adult woman covering a shallow grave with dirt. Deputies dug up the grave and found the body of five year old Enrique. The man (Enrique's father) and woman (Enrique's aunt) were arrested, and the Department of Children and Family Services (DCFS) arrived at the scene and took custody of the three children.

Further investigation by law enforcement and DCFS revealed that the father had been involved with both Enrique's mother and aunt, and had fathered a total of 13 children between them. Previous referrals to DCFS had been received alleging abuse of the children by the father, but allegations had either not been substantiated, or the family could not be located. It was known that Enrique's mother alleged abuse by the father and had left him to seek the safety of shelters on at least two occasions, but had returned to him each time. Each of the surviving children were removed and placed in foster care following Enrique's death.

The Coroner's report stated that Enrique was a five year old boy. He was extremely small (50th percentile in length and 0.5th percentile in weight), and was found buried wearing a diaper. His body was covered with numerous scars. A mark on his abdomen appeared to be from being hit with a wire. He had multiple old and recent

rib fractures, and his forearms were deformed and bent from defensive posturing. His brain showed evidence of both old and recent subdural hematomas. The autopsy was clear: Enrique was a malnourished child who had been severely and repetitively physically abused during his life.

The surviving siblings also showed evidence of chronic abuse and neglect. Each sibling was malnourished and undersized, appearing younger than his or her ages. Several children had old and more recent scarring from being hit with objects. Each child also had language delays. They also confirmed the autopsy findings regarding Enrique's life and death: the father had beaten him numerous times throughout his young life, and neither the mother nor the aunt had ever intervened to protect him or any of the siblings.

Shortly after Enrique was found, Sheriff's detectives investigating the gravesite area found the grave of his sibling, Marisela. Marisela was two years old when she was killed. According to the surviving siblings, Marisela was killed about a year before Enrique. The siblings reported that they had all been living with their father and their aunt in a garage when Marisela awoke one night, crying because she had wet herself. The father reportedly beat her with a belt, then hit her against a wall. The aunt cleaned Marisela up and changed her clothes. But, when she continued to cry, the father beat her with the belt some more and threw her against the wall. She subsequently lost consciousness. The father and mother of Marisela apparently took her up to the forest for burial, assisted by some of the siblings. In order to prevent her identification, the father

Fifty-nine homicides meeting ICAN referral protocol were reported to the Team by the Coroner for 1998. Following review of law enforcement records, ten cases were determined not to have been perpetrated by parents, caretakers or family members. Of these ten cases, eight involved gunshots, including at least five gang-related shootings. In one of these cases, a 2-year old boy was shot and killed during an exchange of gunfire between two rival gangs. In another case the victim was shot as he stood on the landing of his second story apartment. The suspect, who was standing in the street with a group of males, walked up to the victim and shot him three times. The suspect and his companions then drove away in a van. The victim is the brother of an individual who was involved in a neighborhood brawl prior to his murder. In yet another case, the suspect and several other males were playing cards and drinking in a courtyard area near the victim's home. Earlier in the morning the victim's father had asked the suspect and his companions to be quiet because they were disturbing his family. The group subsequently left and the suspect went to a truck, armed himself with a handgun, walked back to the location and opened fire into the victim's house. The victim's parents were also shot but survived the attack. In addition to the eight deaths due to gunshots, there was also one child killed in an arson fire and one child who was strangled.

It should be noted that two of these excluded cases involved children who had an open case with the Department of Children and Family Services (DCFS). In one of these cases, the 12-year old victim was shot by the owner of a furniture store when the boy attempted to rob the store at gunpoint. Although this child was on informal probation, it was not known that he was involved with gangs and it is believed that this involvement with gangs led to this incident and thus contributed to his death. In

the other case, the victim had been placed with a relative due to his mother's substance abuse and her inability to properly supervise him. However, he was abducted from this placement by his mother and at some point became separated from his mother. His body was later found in a trash dumpster and he had been manually strangled to death. He is one of three children in 1998 abducted from their placement through the Department of Children and Family Services who were killed.

This year, as discussed in the Team Protocol section of this report, there were difficulties both in determining which cases to include as a part of the protocol and in ensuring that all cases which fit the protocol were identified. In the process of preparing this report, it became clear that the protocol needed to be revised to become clearer. The Team is also interested in expanding the protocol so that it is more inclusive. As discussed in the Team Protocol section of this report, the Team is working with the Los Angeles County Coroner's office to overhaul the intake system used to determine which cases meet the protocol and should be included in this report. It seems clear from the initial phases of this work that cases that should have been reviewed were either not identified as meeting the protocol or were simply missed and thus are not included in this report. Further, the Team has identified a number of cases that had Los Angeles County agency involvement but were not Los Angeles County Coroner cases. Aside from one case where the autopsy was performed in Mexico (another abduction case of a child abducted from his placement with his Maternal Aunt, taken to Mexico and subsequently killed by his parents), those cases are not included in this report. As a part of the changes to be made in the Team Protocol, the Team must determine how to address these non-Los Angeles County Coroner cases and whether or not to include

them as a part of this report.

Additionally, in an effort to assure that all child homicide cases meeting the protocol are identified, the Team receives data from the California Department of Justice Uniform Crime Reports-Supplemental Homicide File, the California Department of Justice Child Abuse Central Index and the California Department of Health Services Vital Statistics. The child homicide cases listed in these indices are then reconciled with the child homicide cases received from the Coroner's office. This year, the data from these three state indices was not received in time to complete the case conciliation process. However, it is clear from an initial review of this data that there are cases that most likely fit the protocol that were not identified in time to be included in this report.

As a result of the above, it is important to note that there are additional cases that have not been identified by the Team and the data reflected below should be viewed with this in mind.

Given these adjustments and the above referenced difficulties with Team protocols and case conciliation, the Team has determined that **there were 49 child homicides perpetrated by parents, caregivers or family members in Los Angeles County in 1998**. This is an increase of 9 % from the 45 child homicides by parents, caregivers or family members in 1997 and is consistent with the previous 10-year average of 47. Figure 2 displays by year the 471 child homicides by parents, caregivers or family members referred to the Team by the Coroner for the period of 1989 through 1998.

#### **GENDER**

In 1998, 55% (n=27) of the victims of child homicide by parents, caregivers or family members were female, while 45% (n=22) of the victims were male. Over the past 10 years, there have been a total of 255

male victims (54%) and 216 (46%) female victims.

The percentage of female victims has ranged from the low of 29% in 1995 to a high of 61% in 1993. The number of female victims varied little until 1994, averaging 21 per year and ranging from 21 to 26. Since then, other than 1996's number of 25, the number of female victims had ranged from 12 to 17. However, this year's number of 27 is the highest number of female homicide victims over the last ten years.

The number of male victims has had a much greater fluctuation over the past ten years. The average has been 25.5 per year, and has ranged from a low of 16 in 1993 to a high of 35 in 1991 and 1995.

Figure 3 displays the gender breakdown of the child abuse homicide victims for the past 10 years.

#### **AGE**

The ages of the victims of homicide by parents, caretakers or family members between 1989 and 1998 are displayed in Figure 4. In 1998, 33% of the victims were under the age of six months, 43% under the age of 1 year and 59% of the victims were age 2 or younger. 73% of the victims were age 5 or younger and there were five victims of homicide by parents, caretakers or family members who were between the ages 6 and 9. In 1998, eight victims of homicide by parents/caretakers/family members over the age of 10 years were identified.

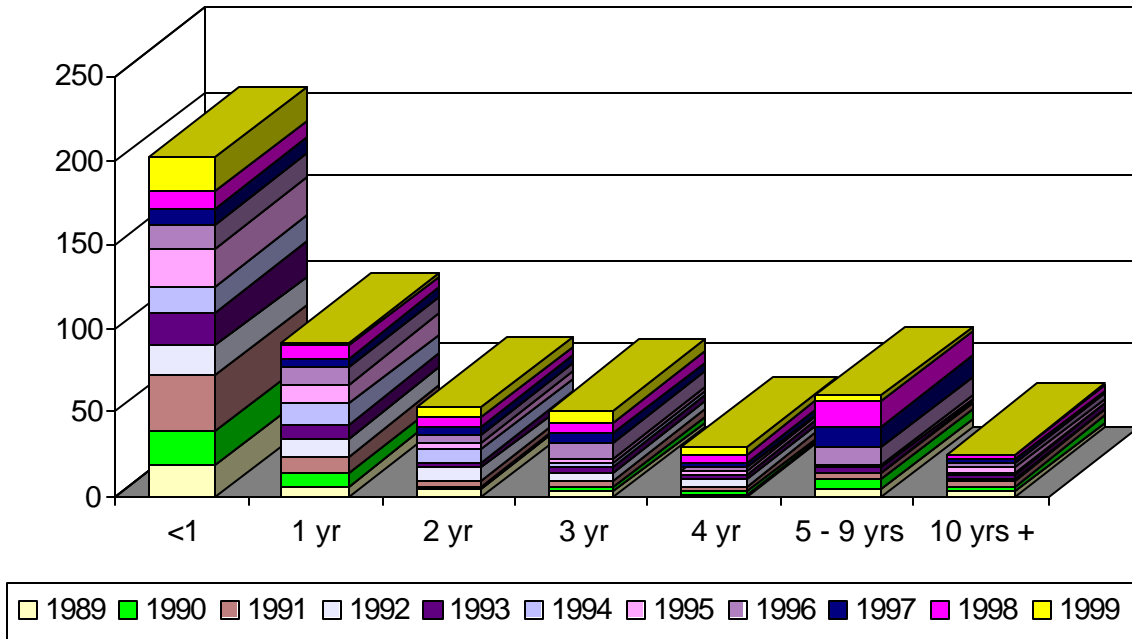
Over the past 10 years, 43% (n=203) of the victims have been under the age of 1 year, 85% (n=400) have been under the age of 5 years.

The ages of the victims in 1998 have risen as compared to the ages of the victims last year. Between 1989 and 1993, approximately 60% to 65% of child victims of homicide by parents, caretakers or family members were under the age of 2 years. In 1994 that level rose to 72% and in 1995 to 73%. However, in 1998 that level has fallen to

CHILD HOMICIDES BY PARENTS/CARETAKERS/FAMILY MEMBERS

**Figure 4**

**1989 - 1999 ICAN CHILD HOMICIDES  
BY PARENTS/CARETAKERS/FAMILY MEMBERS BY AGE**



**Table 1**

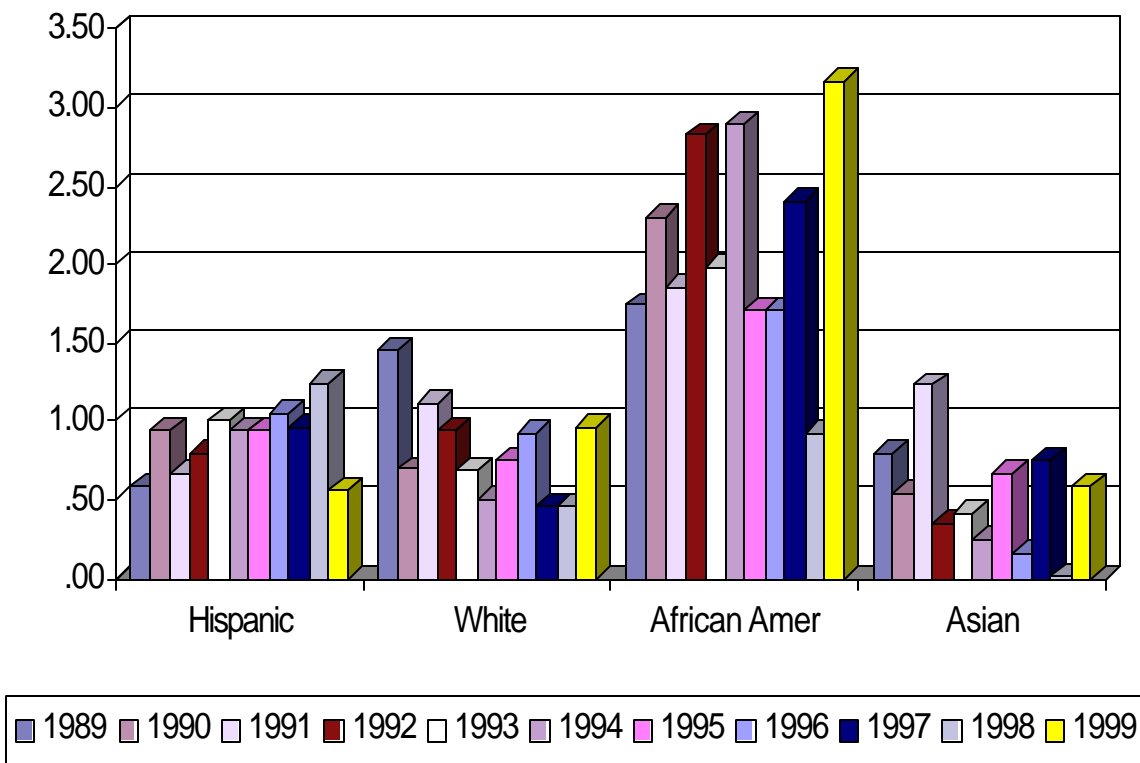
**1999 ICAN CHILD HOMICIDES  
BY PARENTS/CARETAKERS/FAMILY  
MEMBERS BY AGE AND SEX**

Age	Male	Female
less than 1 year	10	11
1 year	0	2
2 years	2	5
3 years	3	3
4 years	3	1
5 years	1	0
6 years	0	0
7 years	0	2
8 years	0	0
9 years	0	0
10 years	0	1
12 years	0	0
13 years	0	0
14 years	0	0
17 years	0	0

CHILD HOMICIDES BY PARENTS/CARETAKERS/FAMILY MEMBERS

**Figure 5**

**1989 - 1999 ICAN CHILD HOMICIDES BY PARENTS / CARETAKERS / FAMILY MEMBERS**  
 - ETHNICITY % COMPARED TO POPULATION %



**CAUSES OF DEATH**

In 1998, the leading cause of death in child homicides by parents, caretakers and family members was head trauma, claiming the lives of 26.5% (n=13) of the victims. Deaths due to gunshots was the second leading cause of death comprising 20.4% (n=10) of the cases.

Table 3 and Figure 6 display the different causes of child homicide by parents/caretakers/family members for the period between 1989 and 1998. The most frequent cause of death for all ten years, and comprising 35.4% of all child homicides by parents/caretakers/family members was head trauma. Multiple trauma was the second most frequent cause of death, representing 16.1% of the total deaths. Homicide by

guns represented the third most frequent cause of death over the previous nine-year period, but this year became the second leading cause of death. Deaths due to gunshots represent 11.4% of the total homicides by parents/caretakers/family members over the past ten years. Gunshot victims in 1998 included a newborn and her 17 year old mother (maternal assault), a family of three siblings ages 13, 9 and 4 who were shot by their father, another family of two siblings ages 3 and 1 who were shot by their mother and a 1 year old who was shot by her father and then buried in the forest.

CHILD HOMICIDES BY PARENTS/CARETAKERS/FAMILY MEMBERS

**TEMPORAL PATTERN**

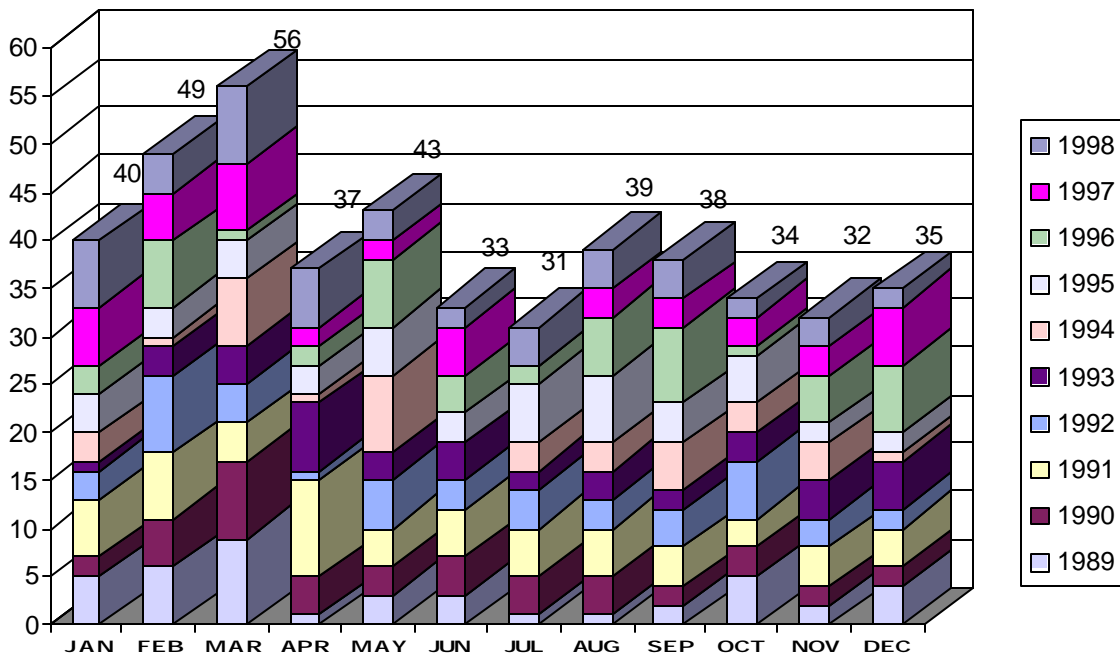
In 1998, the greatest number of child homicides by parents/caretakers/family members occurred in March (n=8). The second greatest number of homicides occurred during January (n=7). The fewest number of homicides occurred in June, October and December (n=2). At least 2 child homicides by parents/caretakers/family members occurred in every month of 1998.

Figure 7 displays the child homicides by parents/caretakers/family members by month for the past ten years. During the period of 1989 through 1998, the greatest

number of child abuse homicides occurred during the month of March. The least number of child homicides by parents/caretakers/family members have occurred during July and November.

The 471 homicides by parents/caretakers/family members during the past ten years translates to an average of 3.9 per month. While actual deaths in any given month vary, June 1994 and July 1997 were the only months in the past ten years in which no child homicides by parents/caretakers/family members were recorded.

**Figure 7**  
**1989 - 1999 ICAN CHILD HOMICIDES BY PARENTS / CARETAKERS / FAMILY MEMBERS BY MONTH**



Twenty of the families in which there was a child homicide by parent/caretaker/family member had a record of contact with the Department of Children and Family Services (DCFS) prior to the death of the child. These 20 families represent 40.8% of the total child homicides by parents/caretakers/family members. This rate is comparable to the national average of 41% reported by the National Committee to Prevent Child Abuse (1997). Four cases were open at the time of the child's death.

For the period of 1989 through 1992, there were eleven families each year with DCFS contact prior to the child's death. In 1993, 13 families had received prior DCFS contact, in 1994, 12 families received prior DCFS contact, in 1995, 15 families received prior DCFS contact, in 1996, 13 families had received prior DCFS contact and in 1997 15 families had a record of prior DCFS contact. Figure 8 displays the number of homicides by parents/caretakers/family members with prior child protective services when compared to the total number of cases for the past 10 years.

The twenty cases with prior referrals to DCFS accounted for a total of 32 prior referrals. Of these twenty cases 75% (n=15) of the families had one prior referral and 10% (n=2) had two prior referrals. There were also two families that had four prior referrals and one family that had five prior referrals to DCFS.

The reasons for prior DCFS services are listed in Table 4. In 1998, 37.5% (n=12) of the prior case openings were for allegations of neglect. Allegations of physical abuse (n=10) accounted for 31% and allegations for caretaker absence/incapacity (n=6) accounted for 18.7% of the referrals. There were also allegations for sexual abuse (n=1), pre-natal drug exposure (n=1), and one allegation of child endangerment related to domestic violence. In one case the reason for the prior referral was unknown.

Compared to prior years, 1998 was only the second time in six years that physical abuse was not the most frequent reason for prior DCFS services. In 1989, 1992, 1994, 1995 and 1996 the most frequent reason was physical abuse. In 1990, 1991 and 1997, the most frequent reason was for neglect. In 1993, the most frequent reason was prenatal substance abuse.

Table 5 provides a comparison between the date that DCFS opened the prior child protective services case and the date of the children's deaths. Fifteen of the 32 prior referrals had been opened in the 6 months prior to the child's death. In fact, in one of these cases four referrals for general neglect were made to DCFS over the three month time period before the child's death, including one referral seven days prior to the child's death from starvation and malnutrition. In three other cases, DCFS had received referrals for physical abuse within two to five months of the child's death and after investigation had closed the cases based on medical opinions indicating minimal concerns for child abuse. All three children were subsequently beaten to death by their caregivers. Of the other prior referrals, one had been opened between 6 months and 1 year prior to the child's death and five of the referrals had been opened over 1 year prior to the death. This pattern is similar to prior years.

In the twenty cases (totaling 32 referrals) that had prior DCFS contact, DCFS had proceeded with Dependency Court action on six of them. In the fourteen other cases, the allegations were either unfounded or unsubstantiated or the situation was stabilized and the case was subsequently closed. Short-term interventions of no more than 3 months were provided in seven of these fourteen cases.

CHILD HOMICIDES BY PARENTS/CARETAKERS/FAMILY MEMBERS

**Table 6**

**1998 ICAN CHILD HOMICIDES BY PARENTS / CARETAKERS / FAMILY MEMBERS**

REASONS FOR CHILD PROTECTIVE SERVICES FOLLOWING THE DEATH

Reason	n	%
Physical abuse	26	96
Severe neglect	1	4

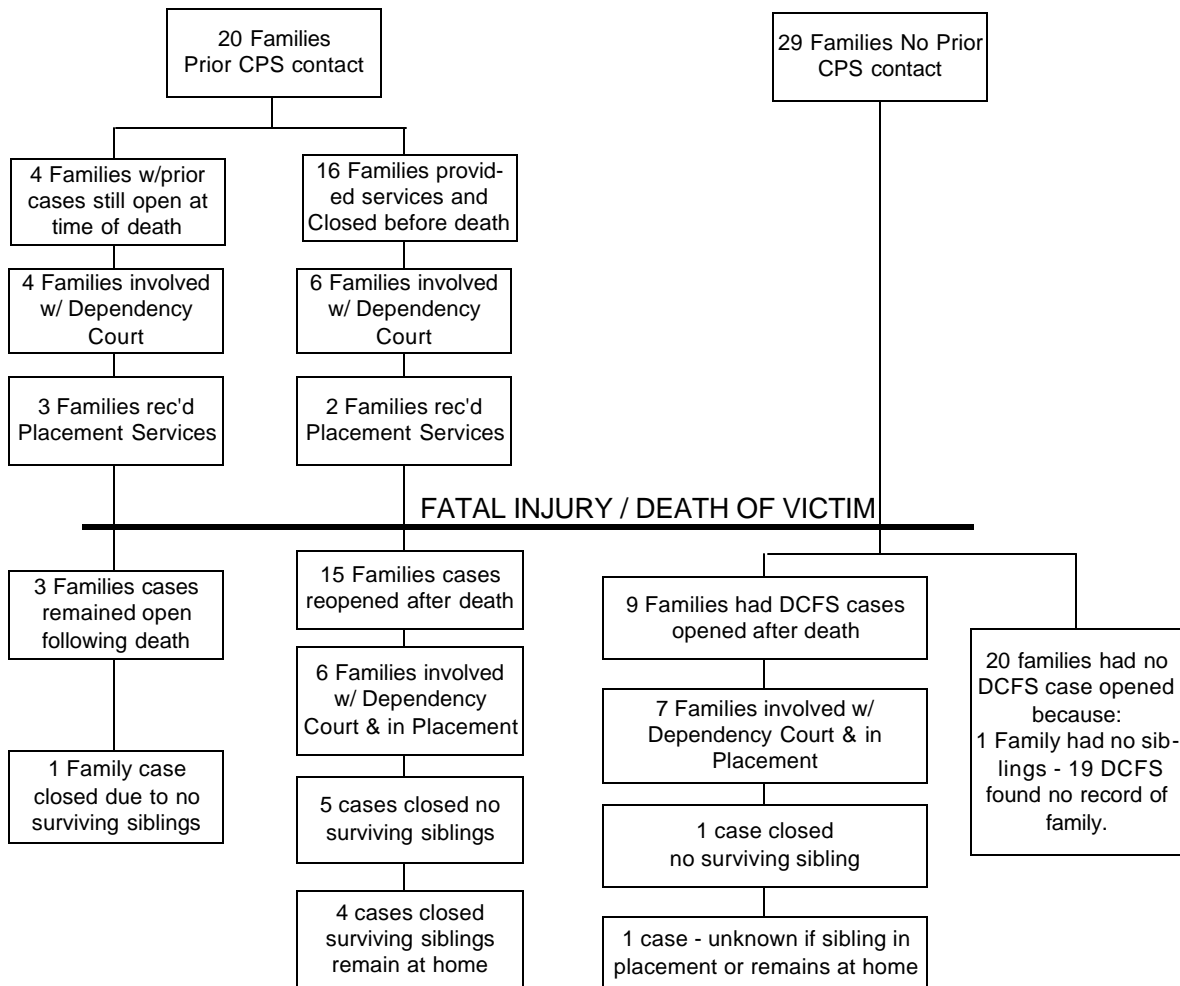
**Table 7**

**AGES OF MOTHERS IN 1998 ICAN CHILD HOMICIDES BY PARENTS/CARETAKERS/ FAMILY MEMBERS**

Age	n	%
Under 20 years	4	13
20 to 24 years	8	27
25 to 29 years	3	10
30 to 34 years	9	30
35 years and over	6	20

**Figure 9**

**CHILD PROTECTIVE SERVICES ACTIVITIES ON 1998 CHILD HOMICIDES BY PARENTS/CARETAKERS/FAMILY MEMBERS**



that the mother had been arrested for the death of the child's sibling.

Petitions were filed in Juvenile Dependency Court on siblings of the deceased child in 16 cases following the child homicide by parent/caretaker/family member. 34 siblings in 15 families were removed from the home and placed in out-of-home care. (Note: there are 15 families from these 16 cases as there were two children from the same family who were brutally murdered by their father and buried in the Angeles National Forest. There are 5 surviving siblings from this family. In addition, there were two other families where there were multiple murders. In one of these families the father shot and killed all 3 children leaving no surviving siblings. In the other case, the mother attempted to kill all 5 of her children by deliberately setting a fire. In this case, 4 of the children were killed and 1 child survived. This child remains placed with his father.)

Figure 9 summarizes the child protective services involvement in the 1998 child homicides by parent/caretaker/family member.

The Department of Children and Family Services provides information regarding demographics of families known to either them, or the Department of Public Social Services through the Child Welfare Services/Case Management Services (CWS/CMS) Information System. These data include:

- 53% (n=26) of the families in which a child homicide by parent/caretaker occurred, had a history of receiving public assistance from the Department of Public Social Services. Between 1989 and 1997, the percentage of families with prior public assistance ranged from 49.2% to 62.5%.
- The mother's age was known in 61% (n=30) of the cases. In 1998, the average age of the mothers was 28.2 years; 40% of the mothers were under the age of 25

years at the time of their child's death. Between 1989 and 1995, the percentage of mothers whose age was below 25 ranged from 42.4% to 84%, but this percentage has dropped in the last few years. In 1996 this percentage dropped to 27.2% and in 1997, the percentage was 39%.

- The father's age at the time of death of the child was known in 42.8% (n=21) of the families. The average age of the fathers was 32.5 years.
- The deceased child had siblings in at least 53% (n=26) of the families. The percentage of families in which there were siblings has ranged from a low of 38% in 1991 to 1996's high of 72%.
- 38.7% (n=19) of the families had a known history of domestic violence.
- 14.2% (n=7) of the families had a known history of substance abuse.

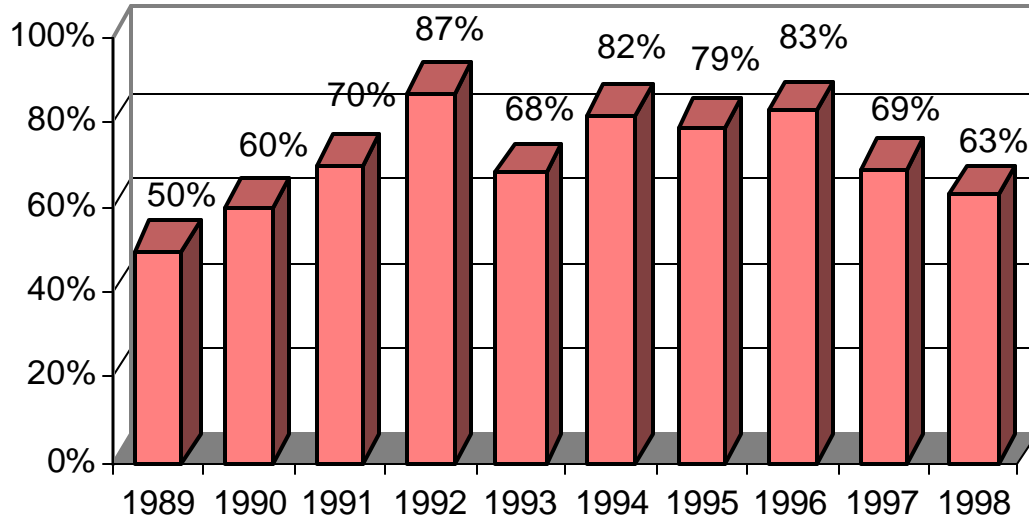
*The actions of the doctor in this case were reported to the Medical Board. When interviewed by law enforcement about his actions and statements, he stated that he was not instructing the family what to do, but was informing them of their options. The doctor was apparently reluctant to testify in this case due to his alleged concerns about breaking doctor-patient confidentiality.*

*The Team was very concerned about the actions of the doctor in this case. Filing of a misdemeanor charge of failing to report the suspected child abuse/homicide, as well as possible discipline by Medical Board against the doctor is pending.*

CHILD HOMICIDES BY PARENTS/CARETAKERS/FAMILY MEMBERS

**Figure 10**

**1989 - 1998 LAW ENFORCEMENT PRESENTATION % OF ICAN CHILD HOMICIDES BY PARENTS/CARETAKERS/FAMILY MEMBERS**



**Table 9**

**LAW ENFORCEMENT REASONS FOR NOT PRESENTING 1998 ICAN CHILD HOMICIDES BY PARENT/CARETAKERS/FAMILY MEMBERS**

	n	%
Murder/suicide	7	38.25
Suspect's identity unknown	5	28.25
Insufficient Evidence	4	22.50
Pending further investigation	1	5.50
Death Occurred in Mexico	1	5.50

CHILD HOMICIDES BY PARENTS/CARETAKERS/FAMILY MEMBERS

**Table 10**

**CRIMINAL CHARGES FILED ON 1989 - 98 ICAN CHILD HOMICIDES BY PARENTS/  
CARETAKERS/FAMILY MEMBERS**

	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
Murder (187 P.C.)	14	16	28	30	12	21	32	37	19	23
Child abuse causing death (273ab P.C.)							23	16	12	16
Child endangerment (273a(a) P.C.)							9	5	6	5
Child endangering (273a(1) P.C.)	7	7	13	11	12	9	3	3		
Corporal punishment or injury of child (273d P.C.)				5	3	3	1	3	2	4
Child abuse resulting in death (273a(a)2 P.C.)						1		13		
Ex-convict in possession of a firearm (12021 P.C.)						1				
Voluntary manslaughter (192a P.C.)							1	1		
Involuntary manslaughter (192b P.C.)	5	4	6		4			2		2
Lewd and lascivious acts (288a P.C.)	4		1				3			
Use of a deadly or dangerous weapon (12022 P.C.)	1		1							
Kidnapping (207a P.C.)	1	1						1		
Accessory after the fact (37 P.C.)	1				1				2	
Possession of a controlled substance (11350 H&S)	1			1						
Dueling (232 P.C.)	1									
Unlawful detention (278 P.C.)		1								
Obstructing or resisting arrest (69 P.C.)			1							
Battery against a peace officer (243b P.C.)			1							
Conspiracy (182a(5) P.C.)					1			2		
Spousal abuse (273.5 P.C.)					1		1			
Penetration of a genital/anal opening (289 P.C.)					1		1			
Sodomy (286 P.C.)							1			
Torture (206 P.C.)							1			
Forgery / uttering a bad check (476aa P.C.)							1			
Under the influence of a controlled substance (11150 H&S)							1			
Unlawfully causing a fire of any structure (451B)								6		4
Poisoning or adulterating food, drink, medicine (347A)								1		
Criminal storage of firearms (12035 B1)								1		1
Assault producing great bodily injury (245(A) P.C.)									2	

*\*These new Penal Code sections became effective January 1, 1995.*



## CHILD HOMICIDES BY PARENTS/CARETAKERS/FAMILY MEMBERS

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In 1998, as in prior years, there have been a variety of other charges filed by the District Attorney. Charges filed in the past 10 years are illustrated by Table 10.

The relationship of the perpetrators identified by law enforcement for cases in which charges were filed by the District Attorney's Office is displayed in Table 11. In 1998, for the seventh straight year with the exception of 1996, mothers have been identified by law enforcement as the category of caretaker most frequently involved in the deaths of their children.

Fathers were the second most frequent perpetrators identified in 1998. However, as in most previous years, there were more male perpetrators (n=25) identified than female perpetrators (n=24). As has been the case in previous years, more male perpetrators were criminally charged by the District Attorney than female perpetrators.

In 1998, there were multiple perpetrators identified by law enforcement and charged by the District Attorney in 5 cases. In all but one of those cases in which charges were filed, the mother was implicated along with either the child's father or the mother's boyfriend. In the other case the mother was implicated together with the child's stepfather.

Criminal disposition data for the period of 1989 through 1998 is displayed in Table 12. In 1998, 90% of the cases are still in pending status. This is a significant increase over 1997 when 57% of the cases were pending at the time the report was written.

For 1998 cases, there have not yet been any perpetrators sentenced to life in prison. In comparison, 4 perpetrators were sentenced to life in prison in 1997. The number of perpetrators sentenced to life in prison in prior years is 1 in 1996, 3 in 1995, 3 in 1994, 3 in 1993, 5 in 1992, 6 in 1991, 1 in 1990 and 9 in 1989. Some of the perpetrators for 1998 cases may be sentenced to life in prison as the pending matters are resolved.

3% (n=1) of perpetrators of child homicide by parents/caretakers/family members received an intermediate term sentence, 2 to 11 years in prison, in 1998. This compares to 14% in 1997, 10% in 1996, 26% in 1995, 14% in 1994, 28% in 1993, 8% in 1992, 23% in 1991, 0% in 1990 and 31% in 1989.

None of the 1998 perpetrators received jail time of one year or less or a probation order. This compares to 1 in 1997, 1 in 1996, 3 in 1995, 2 in 1994, 2 in 1993, 5 in 1992, 3 in 1991, 8 in 1990 and 1 in 1989.

In 1998, there have been no dismissals to date. For prior years, there has been an average of three acquittals or dismissals, with the exception of 1990, 1993 and 1997 when there was only one dismissal or acquittal for each of those years.

**DEPARTMENT OF HEALTH SERVICES INVOLVEMENT**

*Six week old Aaron was brought to a county hospital with difficulty breathing. He appeared to be very malnourished and he died not long after being admitted to the hospital. Doctors opined that he likely died of respiratory failure. The mother claimed that Aaron weighed 4lbs. 6 oz. at birth, but was released from the hospital the next day. Not long after his birth Aaron reportedly developed a respiratory infection. The mother stated that she took him to a local community health clinic, but was denied service because she had not obtained medical coverage for him. She was allegedly told to take him to a county hospital if his condition worsened.*

*The mother, who was living in a homeless women's shelter at the time of Aaron's death, had previously delivered seven live babies fathered by four different fathers, none of whom was involved with the family or supported his child(ren). Aaron was not premature by date, and was negative for the presence of drugs at birth. Hospital staff were apparently not concerned about Aarons's viability, though the mother's housing status was known, the baby was noted to be slightly jittery at birth, and he was not nipling or feeding well.*

*Aaron's death was initially thought to be a result of SIDS. However, it was later determined that the negligent failure of the mother to ensure timely treatment for Aaron, as well as extreme malnourishment, that ultimately caused his death. For these reasons, the Corner's office ruled his death a homicide.*

*The Department of Children and Family Services (DCFS) did not receive a referral in this case until the Coroner's office made its*

*determination that the death was a homicide. When the referral was received by DCFS, investigators were unable to locate the mother and Aaron's surviving siblings. To date, the mother and children remain whereabouts unknown. There is an arrest warrant out for the mother for welfare fraud.*

*Other than the eventual report to DCFS from the Coroner's office, no referrals were made to DCFS by any of the several agencies that had contact with the mother, family and Aaron prior to his death. Three chances to intervene with a referral to DCFS- at the hospital upon Aaron's delivery, by the community health clinic, and by the homeless shelter- were missed.*

*This case illustrates the reality frequently revealed at death review: that chances to intervene and potentially save a child's life are sometimes missed by several agencies and individuals involved with the child and family prior to the death. In addition, Team discussion focused on the need for expanded public health nurse home visiting programs for high-risk families following a child's birth.*

## ACCIDENTAL CHILD DEATHS IN LOS ANGELES COUNTY

*At approximately 11:00 p.m. LAPD units responded to the scene of an apartment fire with a child reportedly trapped inside. Police officers were met at the scene by several residents of the apartment complex, who advised officers that one year old Shirley was still trapped inside the smoke-filled apartment. Officers attempted to crawl into the apartment two times, but were forced to retreat due to thick smoke and extreme heat. The bedroom was observed to be fully engulfed in flames. Fire Department personnel arrived at the scene shortly after law enforcement and were able to extinguish the flames and enter the bedroom, where Shirley's charred body was found face down on the bed. She had fourth degree burns over her entire body and had no pulse. Her cranium had ruptured due to the extreme heat.*

*LAPD and Fire Department Arson investigators determined that the fire was accidentally caused by Shirley's five year old cousin playing with matches. Shirley's family and extended family occupied two adjoining downstairs apartments. On the day of the fire, the cousin had been playing with matches with other younger relatives in apparent anticipation of a birthday/birthday cake scheduled for the next day. Shirley's mother had earlier caught the cousin playing with matches and scolded her, taking the matches away. However, she apparently found matches in her grandmother's purse in the adjoining apartment. Investigators found both the birthday cake and a book of matches in the room after the fire. The cousin who set the fire initially said that a man had come*

*into the room and thrown a match onto the bed, though she later admitted that she had had thrown a match on the bed where Shirley had been put down to sleep. When the bed caught on fire, the cousin ran next door and alerted the mother and other relatives, but it was too late to rescue Shirley.*

*The autopsy revealed that Shirley had died from smoke inhalation and thermal burns over her entire body. She had apparently been conscious when she was burned.*

*The Department of Children and Family Services (DCFS) had received and investigated a referral about three years earlier that alleged that the mother had been leaving her children alone. The allegations were not substantiated, however, and the case was closed. Following Shirley's death, DCFS opened a voluntary family maintenance case with the family and provided referrals for grief and mourning counseling for the mother and surviving siblings and cousins. In addition, the Red Cross also provided follow-up counseling services to the family after the fire.*

*While the Team had concerns about possible lack of supervision, it was agreed by law enforcement and DCFS that there was insufficient evidence to file any charges in criminal court, or to file a petition in the dependency court. This tragic accidental fire, one of many that occur in the county each year, underscores the extreme danger of fire to children.*

### CAUSES OF ICAN ACCIDENTAL DEATHS

The causes of the Accidental deaths between 1989 and 1998 are displayed in Figure 13 and Table 13. The leading cause of accidental death in 1998 was deaths associated with maternal substance abuse, surpassing drowning as the leading cause of accidental death for the second time since ICAN began tracking this information. The only other year in which drowning was not the leading cause of accidental death was 1996 when there was a 42% decrease in the number of deaths due to drowning and deaths associated with maternal substance abuse was the leading cause of death. Deaths associated with maternal substance abuse are primarily of very young, prematurely born, infants who were prenatally exposed to drugs. In 1998, there were 38 deaths associated with maternal substance abuse, a 58% increase from the 24 such deaths in 1997. The 38 deaths associated with maternal substance abuse are the highest number of these deaths since ICAN began collecting this data. The second highest number was 25 in 1996 and the low was 9 in 1995.

The second leading cause of accidental death in 1998 was deaths due to drowning. There were 21 accidental deaths due to drowning in 1998, a 33% decrease from 1997. This number is the second lowest number of deaths due to drowning since ICAN began tracking this information. The previous low was 18 in 1996 and the high was 40 in 1990 and 1993.

Automobiles vs. Pedestrians (children hit by automobiles) was the third leading cause of accidental death in 1998, with 19 children dying as a result of being hit by a car. This number is a 138% increase over the 8 deaths due to a child being hit by a car in 1997, which represented a 700% increase over the 1 such death in 1996. Prior to 1995, accidental deaths due to automobiles

vs. pedestrians were not referred to the Child Death Review Team. It is likely, however, that the large increases in the numbers of these deaths over the last two years do not represent an increase in the incidence of these deaths, but rather, reflect changes in the Team's data collection which promote greater identification of these deaths by the Team. Tragically, one child was killed when she was run over by her father and another was killed when she was run over by her Aunt.

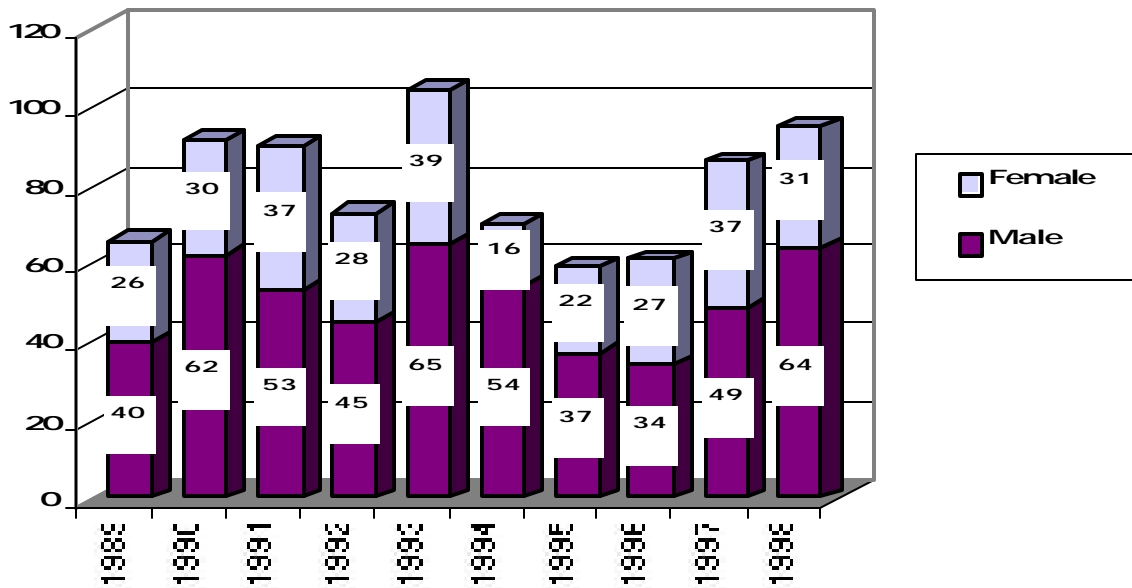
Other causes of accidental deaths, as in prior years, range from falls, choking, fire, injuries of the neck or chest, suffocation, accidental ingestion of drugs or other poisons, including one death from carbon monoxide poisoning, and injuries suffered as a result of objects falling on young children. This array of causes of death is similar to prior year findings.

## ACCIDENTAL CHILD DEATHS

### GENDER

67% (n=64) of the 1998 accidental death victims were male while 33% (n=31) of the accidental death victims were female. Over the past 10 years, the percentage of male victims has ranged from 1996's low of 56% to a high of 77.1% in 1994. Figure 14 displays the gender breakdown of the accident victims for the past 10 years.

**Figure 14**  
1989 - 1998 ICAN ACCIDENTAL CHILD DEATHS BY GENDER





**Table 14**  
**ETHNICITY OF ICAN ACCIDENTAL DEATHS 1998**

	HISPANIC	AFR-AM	WHITE	ASIAN
Maternal drug abuse	5	22	9	2
Drowning	12	3	6	0
Autopedestrian	12	3	3	1
Choking	3	0	0	0
Falls	2	1	0	0
Fire	3	0	0	0
Suffocation	1	0	1	0
Chest/Neck compression	2	0	0	0
Object fell on child	2	0	0	0
Poisoning	0	0	1	0
Medical Misadventure	0	1	0	0
<b>TOTAL</b>	<b>42</b>	<b>30</b>	<b>20</b>	<b>3</b>

**ETHNICITY**

Table 14 displays the causes of accidental deaths in 1998 for the children of different ethnic groups. Hispanic children represented 44% (n=42) of all the accidental deaths in 1998. They suffered the most deaths due to drowning (n=12) and deaths due to a child being hit by a car (n=12). They also suffered all the deaths due to choking (n=3), fire (n=3) objects falling on a child (n=2) and chest/neck compression (n=2).

African American children represented 32% (n=30) of the 1998 accidental child deaths. As in most previous years they suffered the most deaths related to maternal substance abuse; in 1998 they suffered 58% (n=22) of all maternal substance abuse deaths, which is 73% of the 30 total accidental deaths suffered by African American children.

White children represented 21% (n=20) of the accidental child deaths in 1998. 24% (n=9) of the deaths related to maternal substance abuse were white children as were 29% (n=6) of the deaths due to drowning.

There were 3 accidental child deaths of Asian children in 1998, 2 due to maternal substance abuse and one child who was killed by a hit and run driver.

**TEMPORAL PATTERN**

Figure 16 and Table 15 display the incidence of accidental deaths for each month of 1998. The month with the greatest number of accidental deaths was March.

As in past years, the monthly pattern of drowning deaths was compared to all accidental deaths. In 1998, more drowning deaths occurred in the spring and summer (17 of the 21 drowning deaths occurred between April and September). As deaths due to drowning are the most frequent cause of accidental death and as the majority of the drowning deaths occur in the spring and summer, they influence the temporal pattern a great deal. The month of the most non-drowning accidental deaths was November.

## ACCIDENTAL CHILD DEATHS



Of the 22 cases with prior child protective services, three were opened and closed before the birth of the child that died.

DCFS proceeded with court action and out-of-home placement before the death in 45% (n=10) of the families in which they had received referrals for service. 41% (n=9) of the cases that were known to DCFS were open at the time of the children's death. Two other cases, both for allegations of neglect, were closed within one month prior to the child's death. In one of these cases the child was killed when he was hit by a car, in the other, the child died from complications related to maternal substance abuse. All 9 cases that were open to DCFS at the time of the accidental death were open as a result of parental substance abuse. In all but one of these cases, the siblings had been in out-of-home care at the time of the death and remained in out-of-home care after the death.

In addition to the 9 cases that were open to DCFS at the time of the accidental death, 13 additional families were referred to DCFS at the time of the death. Four of the cases that had been opened and closed before the death were reopened. The reason for referrals on the 13 families who had cases opened after the death are displayed in Table 17.

Petitions were filed in Juvenile Court on siblings of the deceased child on 4 cases following the deaths and the siblings were placed in out-of-home care in 2 cases. Of the 9 cases that were open to DCFS at the time of the accidental death, 8 remained open after the death.

Figure 17 summarizes the child protective services on the accidental child deaths.

The Department of Children and Family Services provided information regarding the constellations of families known to them:

- 48% (n=46) of the families had a history of receiving public assistance from the Department of Public Social Services.
- The mother's age at the time of death of the child was known in 32% (n=30) of the families. Table 18 provides a breakdown of the mothers' ages.
- The deceased child had siblings in 29% (n=28) of the cases. 5% (n=5) of the families were known to not have any children other than the victim. It was unknown if there were siblings in 65% (n=62) of the families.

**Table 16**

**1998 ICAN ACCIDENTAL CHILD DEATHS  
REASONS FOR PRIOR CHILD PROTECTIVE SERVICES**

Reason	n	%
Severe neglect	2	9
General neglect	3	14
Caretaker absence/incapacity	5	23
Physical abuse	3	14
Child Endangerment	1	5
Prenatal substance abuse	5	23
Unknown	3	14

**Table 17**

**1998 ICAN ACCIDENTAL CHILD DEATHS  
REASONS FOR CHILD PROTECTIVE SERVICES FOLLOWING DEATHS**

Reason	n	%
Severe neglect	5	38
Lack of Supervision	5	38
Substance abuse	3	23

**Table 18**

**1998 ICAN ACCIDENTAL CHILD DEATHS  
AGE OF MOTHERS**

Reason	n	%
Less than 25 years	5	17
25 to 29 years	7	23
30 to 39 years	14	47
40 years and older	4	13

## ACCIDENTAL CHILD DEATHS



dental deaths receive consideration by the District Attorney due to the Coroner's ruling that the death was accidental. Three of the four cases presented involved deaths where the child was hit by a car. The other case presented was a fetal death due to maternal substance abuse. Of these cases, two of the cases where a child was hit by a car were rejected by the District Attorney's Office. One case was rejected because it was determined that there was no criminal negligence and one, where it was believed that the driver of the car had been driving under the influence of alcohol, was rejected

because there was insufficient evidence of a crime. Apparently, the suspect's blood alcohol level was never taken. The case relating to maternal substance abuse was also rejected by the District Attorney's Office. One case where a child was hit by a car did result in the filing of charges by the District Attorney. In this case the suspect was charged with one count of assault with a deadly weapon (PC 245) and two counts for hit and run (VC 20001). A bench warrant for the suspect in this case has been issued but he remains at large.

**Table 19**  
**LAW ENFORCEMENT AGENCY INVOLVEMENT IN 1998 ACCIDENTAL CHILD DEATHS**

LAPD	44
LASD	25
Long Beach P.D.	7
California Highway Patrol	4
Compton P.D.	3
Pasadena P.D.	3
Azusa P.D.	1
Baldwin Park P.D.	1
Bell P.D.	1
Inglewood P.D.	1
Monterey Park P.D.	1
Pomona P.D.	1
San Gabriel P.D.	1
West Covina P.D.	1
Whittier P.D.	1

### HEALTH SYSTEMS INVOLVEMENT IN ACCIDENTAL CHILD DEATHS

As noted in the homicide section of this report, record searches for some of the 1998 cases were able to be conducted at all 4 Los Angeles County Department of Health Services facilities. Records for 15 of the 95 children who died as the result of an accidental death were found. 8 records were found at Harbor/UCLA Medical Center, 4 at LAC/USC Medical Center, 2 at Olive View Medical Center and 1 at King Drew Medical Center. Multiple records were found for 2 children.

35 different medical facilities were identified as the place of death for 86 of the children who died from accidental deaths. In addition, eight of the children who died from an accidental death had their residence listed as their place of death and one had the street where he was killed when he was hit by a car listed as the place of death. ☹

## UNDETERMINED DEATHS IN LOS ANGELES COUNTY

*LAPD responded to the scene of an unresponsive 10 month old child. The child's mother, age 16, reported that Melinda had been fed, was laid on the floor to sleep, and when she returned to check on her ten minutes later, Melinda was not breathing. However, when officers noted what appeared to be ligature marks around Melinda's neck, they confronted the mother, who then admitted that Melinda had been put down to sleep in a makeshift hammock tied with ropes, a common sleeping practice in the mother's culture. The mother claimed that when she checked on Melinda she had fallen out of the hammock and was on her knees, with rope from the hammock tangled around her neck. When she discovered Melinda she became scared and took the hammock down. Detectives later had the mother recreate how the hammock was made and how she found Melinda. The detectives determined that the story made sense and explained the injuries noted on Melinda.*

*The Coroner found that the pattern of ligature marks on Melinda matched the texture of the rope used to hang the hammock. The autopsy also revealed that Melinda had a torn upper frenulum, as well as tears to her anus and vagina. A catheter used at the hospital could possibly have caused the vaginal tear. A sexual abuse kit was negative, and the Coroner could not say if the noted anal and vaginal tears were caused by sexual abuse, though this possibility could not be excluded, either. Melinda died as a result of asphyxia. Given the torn frenulum and vaginal and anal tears, however, the Coroner ruled the mode of death as undetermined.*

*A doctor on the Team with many years of experience in sexual abuse exams reviewed the autopsy photos and determined that the torn anus appeared to be very consistent with penetration, but cautioned that such injuries are more visible post-mortem, thus while the noted injuries were very suggestive of sexual abuse, they were not diagnostic of abuse.*

*The Department of Children and Family Services detained Melinda's mother and the other minor children in the home due to the possibility that sexual abuse may have occurred. At the time of Melinda's death, there were three sets of families living in the home, and seven people were in the home at the time of the death. The sixteen year old mother denied having a boyfriend and was very evasive about the identity of Melinda's father. There was suspicion that Melinda's father could have been one of the adult men residing in the home, or perhaps even her own maternal grandfather. When the final Coroner's report and law enforcement investigations were completed without any clearly identified sexual abuse, the dependency court case was dismissed and the minor children were returned to the home.*

*The Team was very concerned about the mother and minor children returning to the home, given concerns about the still unexplained causes of the vaginal and anal injuries suffered by Melinda. Cases such as this serve to reinforce the Team's support for expanded home visiting programs for high-risk parents and families following a birth.*

Syndrome (SIDS) death of a 3-month-old boy, but upon investigation, it was found that the victim had a twin sister that died at the age of 13 days from an undetermined cause. The mother had a history of substance abuse and had gone to sleep on a couch with her 3-month old son by her side. When she awoke, she found him not breathing. The cause of death for this child and for his 13-day-old twin sister could not be determined by the Coroner and both cases are still under investigation. In another similar case, the mother had been feeding her 2-month old daughter when she fell asleep. Upon awakening, she found that her daughter was "still" and got no response when she attempted to arouse her. The child was transported to the hospital where she was pronounced dead. However, the Coroner was unable to determine a cause of death. In another case involving an interuterine death, law enforcement reported that the mother had been strangled by her boyfriend, leading to her death and the death of her fetus. However, the mother also had a history of cocaine use and her cause of death could not be determined by the Coroner. In yet another case, a 1-year-old boy was found not breathing by his grandmother. At the hospital, it was noted that the child had blood in his mouth and airway. However, no signs of trauma could be found and the cause of death could not be determined.

Four of the undetermined deaths in 1998 involved infants whose bodies had been dumped; one in a sewer line, one in an aqueduct, and two in trash cans.

The diversity of causes of undetermined deaths is consistent with prior year findings.

#### **DEPARTMENT OF CHILDREN AND FAMILY SERVICES INVOLVEMENT**

Eleven (39%) of the undetermined deaths in 1998 had prior child protective services involvement, and four of those cases were open to the Department of Children and Family Services at the time of the death.

The reasons for involvement included substance abuse of parents, physical abuse, emotional abuse, and severe neglect. Two families had 2 prior referrals to DCFS, and six families had 1 prior referral. Other than the four cases that were open to the Department of Children and Family Services at the time of the death, none of the cases with prior DCFS involvement resulted in court action or out-of-home placement.

On one case with a prior referral to DCFS due to the minor's testing positive for drugs at birth, the case was closed after 2 months. It is unclear from the information provided what services were provided to the family. Three months after the case was closed, the mother left her infant son with some friends to care for him overnight. When they checked on him in the night they found that he was having trouble breathing and they called 911. The child was taken to the hospital where he died a few days later. The cause of death is related to acute bronchopneumonia and other undetermined factors. The mother is now whereabouts unknown. In another case of two twins, a female who died 13 days after birth and a male who died 3 months after birth, DCFS had a prior referral on the family 4 years prior to the birth of these children. The reason for this referral is unknown. In this case, the mother has a history of substance abuse and in both cases the Coroner has been unable to determine a

Coroner's findings. This child died from asphyxia and other undetermined causes. She also had a dilated and torn anus. Ultimately, it was determined that the mother had taken an infant seat and hung it in the doorway so that it would act like a swing for the infant. However, the baby was not strapped in well and slipped, thereby strangling herself in the seat's straps. No explanation for the torn anus was ever determined but the case was closed as there were no siblings.

In the past, deaths related to undetermined causes have not usually resulted in court involvement and/or out-of-home placement for the surviving siblings.

#### **CRIMINAL JUSTICE SYSTEM INVOLVEMENT**

The Los Angeles Police Department was the investigating law enforcement agency on 32% (n=9) of the undetermined deaths and the Los Angeles Sheriff's Department was responsible for the investigations on 36% (n=10) of the cases. Four cases were handled by the Long Beach Police Department and five other cases were handled by five different police agencies.

One case was presented to the District Attorney's Office by law enforcement for the filing of criminal charges. This number is an 86% decrease from the seven cases that were presented in 1997. In the case that was presented by law enforcement, the mother's boyfriend had strangled her resulting in her death and the death of her fetus. It is likely that murder charges will be filed in this case but the investigation is on-going and no charges have been filed yet. In two additional cases, law enforcement has not yet presented the cases to the District Attorney's Office for the filing of criminal

charges but the investigations remain open and the cases may be presented upon completion of these investigations. In one case, a 9-month old male had been in the care of his babysitter and was found unconscious and unresponsive in his crib. He was subsequently pronounced dead by paramedics at the babysitter's home. At the time of death no signs of trauma were noted. Upon autopsy, it was discovered that the infant had healing rib fractures that were likely from a prior inflicted injury. However, no cause of death could be determined by the Coroner. The circumstances surrounding the death and this prior injury are suspicious but law enforcement stated that there was insufficient evidence to present the case for the filing of criminal charges. The investigation also remains open in the deaths of two twins, one who died after 13 days and one who died after 3 months. Both cases may be related to maternal substance abuse but the Coroner was unable to determine a cause of death in both of these cases and there is insufficient evidence of a crime at this time.

#### **HEALTH SYSTEM INVOLVEMENT**

Three of the undetermined deaths had records at Los Angeles County Department of Health Services facilities: 2 at Harbor/UCLA Medical Center and 1 at King Drew Medical Center. In all three of these cases, these facilities were not listed as the place of death.

Place of death data provided by the Coroner indicated that 14 different medical facilities were involved in the undetermined deaths. Three of these victims died in Los Angeles County Department of Health Services facilities. The remaining victims either died at their residence or at other

## ADOLESCENT SUICIDES IN LOS ANGELES COUNTY

*Fifteen year old Raymond was found by his mother hanging by an electrical cord from the rafters of the family garage. He and his mother had recently moved to the area and he had reportedly been depressed about school and family problems.*

*Fifteen year old Andrew was found hanging from a bedsheet tied to a bunk bed in a cell at a juvenile detention center. He was incarcerated pending trial on sexual molestation charges, and he had spent most of his young life involved with the juvenile justice system.*

*Seventeen year old Serena placed a rifle in her mouth and pulled the trigger. There had been no previous involvement with child protective services or the juvenile justice system. She left no note explaining why she killed herself.*

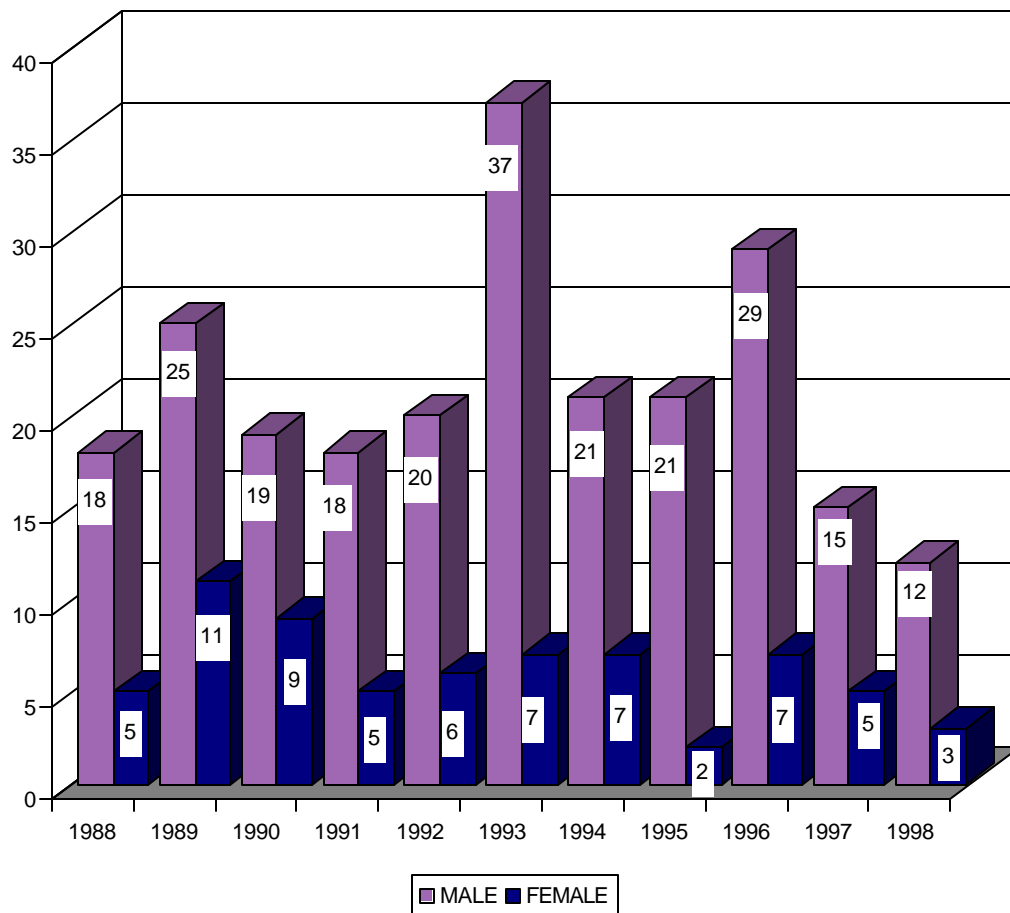
*Thirteen year old Janelle placed her head between the wrought iron bars bordering her residence. Responding officers found a suicide note at her feet.*

*Seventeen year old Danny had an argument with his father, after which he went to his room, which was a detached structure adjacent to the family residence. When he was not seen for a couple of hours, his father went to his room and found him dead with a gunshot wound through his eye. He was found gripping a .44 caliber revolver in his right hand.*

*Sixteen year old Ronald was upset about learning of his father's plan to move the family from their current residence. The father went outside after arguing with his son about the pending move. When he entered the house a short time later, he found his son in a hallway, dead from a gunshot wound to the head. No suicide note was left.*

*These cases illustrate the continuing tragedy of youth suicide. Data from 1998 indicate that there were 15 suicides of youth aged 12 to 17, the fewest since ICAN began collecting and reporting data on such suicides in 1988. Between 1988 and 1997, an average of 28.7 youth suicides per year were reported to ICAN.*

**Figure 18**  
**1988 - 1998 ICAN ADOLESCENT SUICIDES BY GENDER**



**AGE**

In 1998, the average age of adolescent suicide victims increased from 14.6 years to 15.2 years, the same as in 1996. This increase may primarily be due to the decrease in the number of 11, 12 and 13 year olds who committed suicide in 1998 as compared to previous years. There were decreases in the number of suicides of most ages with the exception of age 14 where there was an increase (from 0 in 1997 to 2 in 1998). The largest decrease was in the

number of 13 year olds, from 4 in 1997 to 1 in 1998. Table 20 displays this data, as does Figure 19.

The two youngest victims in 1998 were 12 and 13 years old. There were two 14 year old and four 15 year old victims. 11 of the 15 victims were 15, 16 or 17 years old. 1998 is the third straight year since ICAN began collecting this data that there were more 16 year old victims than 17 year old victims.

**ETHNICITY**

In 1998, 80% of adolescent suicides were committed by Hispanics (n=12). This represents a 33% increase from 1997. The number of White adolescents decreased from 13 in 1996 to 6 in 1997 and now to 3 in 1998, a 50% decrease and 20% of the total number for 1998. The number of African-American adolescent suicides decreased as there were 4 in 1997 and none in 1998. The number of Asian youth who committed suicide also decreased as there was 1 in 1997 and none in 1998.

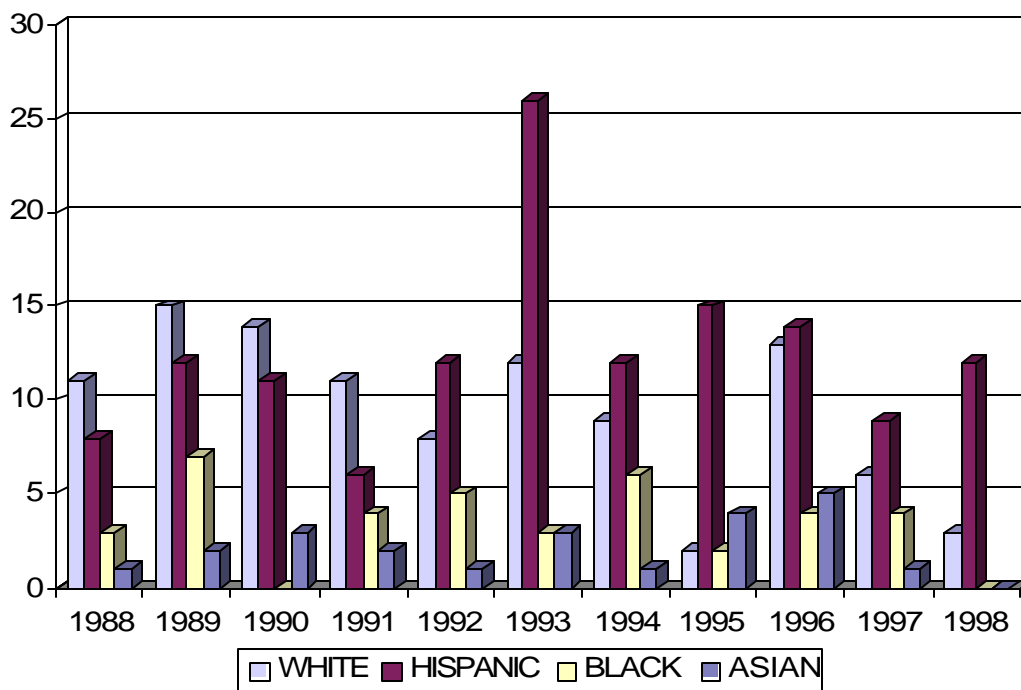
When compared to child population statistics, Hispanic youth were significantly over-represented in 1998 while African-American, White and Asian adolescents were underrepresented.

From a multi-year perspective, as illustrated in Figure 20, Hispanic youth average

the greatest number of suicides ( $x = 12.9$ ), with White youth following ( $x = 9.3$ ). The number of White youth committing suicide decreased in 1997 and 1998, after an increase in 1996, but consistent with the prior five years of a decrease in these numbers. There continues to be an increasing percentage of Hispanic youth committing suicide, just as the number of Hispanic youth in the population continues to increase. In 1998, an extremely high percentage of the adolescent suicides (80%) were committed by Hispanic youth.

The number of African-American youth who have committed suicide over the past 10 years has averaged 3.5 per year, with a range of 0 to 8. The number of Asian adolescents committing suicide has averaged 2.2 per year, with a range of 0 this year to 1996's high of 5.

**Figure 20**  
**1988 - 1998 ICAN ADOLESCENT SUICIDES BY ETHNICITY**



**TEMPORAL PATTERN**

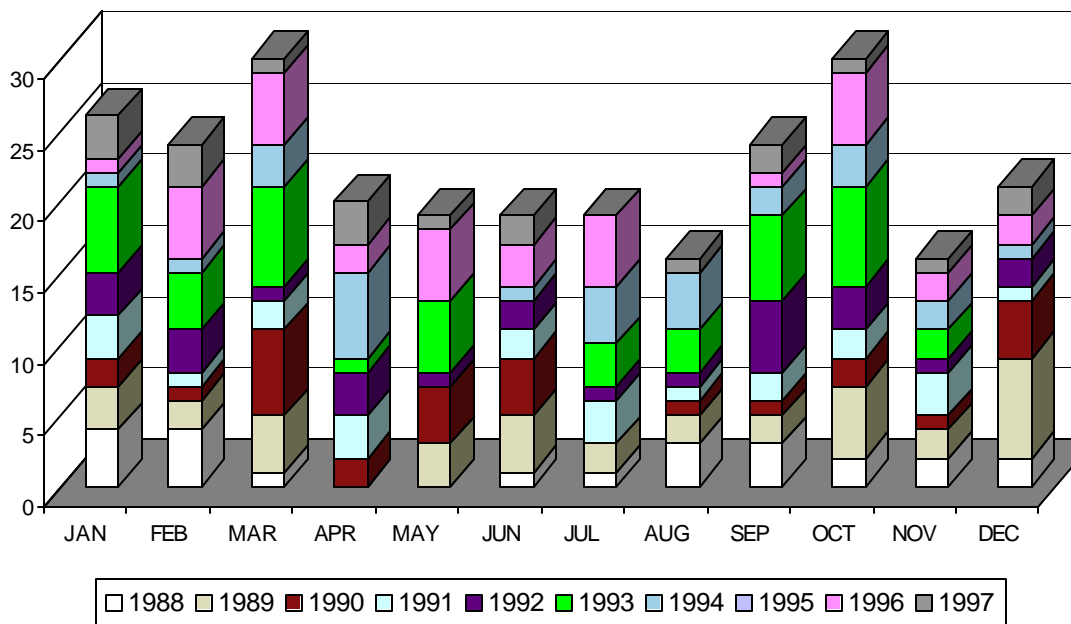
Figure 22 displays the temporal pattern of adolescent suicide deaths from 1988 through 1998.

In 1998, there were six adolescent suicides in February, two in March and two in April. In other words, one period of three consecutive months (25% of the year) accounted for 67% of the suicides. In five months ( January, May, August, September

and October) there was one adolescent suicide each and in four months (June, July, November and December) there were no adolescent suicides.

Over the period 1988-1998, the months having the greatest number of suicides are March, October, February and January.

**Figure 22**  
**1988 - 1998 ICAN ADOLESCENT SUICIDES BY MONTH**





cases), general neglect (8 cases), and caretaker absence/incapacity (1 case). In one case the reason for referral was unknown. Table 21 displays the reasons for prior DCFS services on cases between 1989 and 1998.

From the information provided, it does not appear that any of the cases with prior DCFS involvement were open to DCFS at the time of the death. Over the past 10 years, the average percent of families of suicide victims with prior DCFS involvement is 23.5%, ranging from a low of 4% (1 of 23 cases) in 1995 to this year's and last year's high of 40% (8 of 20 cases). In 1998, there were no DCFS cases opened to assess siblings as the result of the suicide.

**DEPARTMENT OF PUBLIC SOCIAL SERVICES INVOLVEMENT**

33% (n=5) of the families of adolescent suicide victims had a history of receiving public assistance from the Department of Public Social Services. Three of the families that had a history of DPSS involvement also had a history of DCFS involvement.

Over the past 10 years, the number of families known to DPSS has averaged 26.7%, ranging from 1995's low of 13% to 1992's and last year's high of 35%.

In 1998, it was known that there were siblings on 4 cases. Two of these cases were known to DCFS and 2 of these cases were known both to DCFS and to DPSS. On one additional case known to DCFS, it was known that there were no siblings. For the remaining 10 cases, it is unknown if there were any siblings.

**Table 21**

**REASONS FOR PRIOR DCFS SERVICES FOR ADOLESCENT SUICIDES 1989 - 1998**

	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	Total
Sexual Abuse	1		3		3	1		3	3	4	18
Physical Abuse	1	1	1		2	2		2	5	5	19
Severe Neglect	3			1	1			1			6
General Neglect	1			1	3	1		1	1	8	16
Emotional Abuse					3		1				4
Caretaker absence									1	2	3
Info. unavailable	6	2	1	2	2	1		2	1	1	18
<b>TOTAL</b>	<b>12</b>	<b>3</b>	<b>5</b>	<b>4</b>	<b>14</b>	<b>5</b>	<b>1</b>	<b>9</b>	<b>11*</b>	<b>20*</b>	<b>84</b>

\* Some families had more than one prior referral to DCFS

**Table 22**

**LAW ENFORCEMENT AGENCY  
INVOLVEMENT IN 1998 ADOLESCENT  
SUICIDES**

**LAPD**

Harbor Division	2
West Valley	2
Northwest Division	1

**LASD Homicide** 7

**Bell Gardens P.D.** 1

**Compton P.D.** 1

**Long Beach P.D.** 1



## FETAL DEATHS IN LOS ANGELES COUNTY

*Twenty-one year old Diana walked into the emergency room of a county hospital complaining of vaginal bleeding. She was seven months pregnant and had gone into pre-term labor. The fetus was delivered stillborn within minutes of the mother's arrival at the emergency room. Blood and urine tests of both the mother and the fetus revealed that both had cocaine in their systems. The mother admitted that she had used cocaine earlier in the day, and that she began to have labor pains immediately after her last "hit" of cocaine.*

*The mother, who had two other drug-exposed babies earlier in her life, indicated that she had used cocaine "off and on" during the pregnancy and had not received any prenatal health care. She also admitted that she drank beer "to help with sleep" during the pregnancy as well. Diana's two surviving children were in separate homes, awaiting formal termination of parental rights. The fathers of the children were whereabouts unknown, and the mother had failed to comply with the court-ordered case plan, which included substance abuse treatment.*

*The Department of Children and Family Services had been involved with the mother for many years, first as a dependent of the court herself, then as a parent. She had entered drug treatment on three separate occasions, but failed to commit to the programs each time, dropping out as her cocaine addiction dominated her life. She*

*had very limited extended family support, and had difficulty finding stable housing. At the time of the fetal death, she had been staying at a homeless women's shelter.*

*The Coroner's report revealed that the fetus died of intrauterine cocaine exposure and cocaine-induced pre-term delivery. The fetus was noted to be very small for his gestational age, apparently due to the maternal cocaine and alcohol abuse and poor nutrition and health care during the pregnancy.*

*This case was typical of fetal deaths reported by the Coroner to ICAN during 1998, the majority of which involved fetal deaths due to maternal abuse of drugs and/or alcohol. These cases provide additional evidence of the great risk to fetal and maternal health posed by the abuse of drugs and alcohol by expectant mothers.*

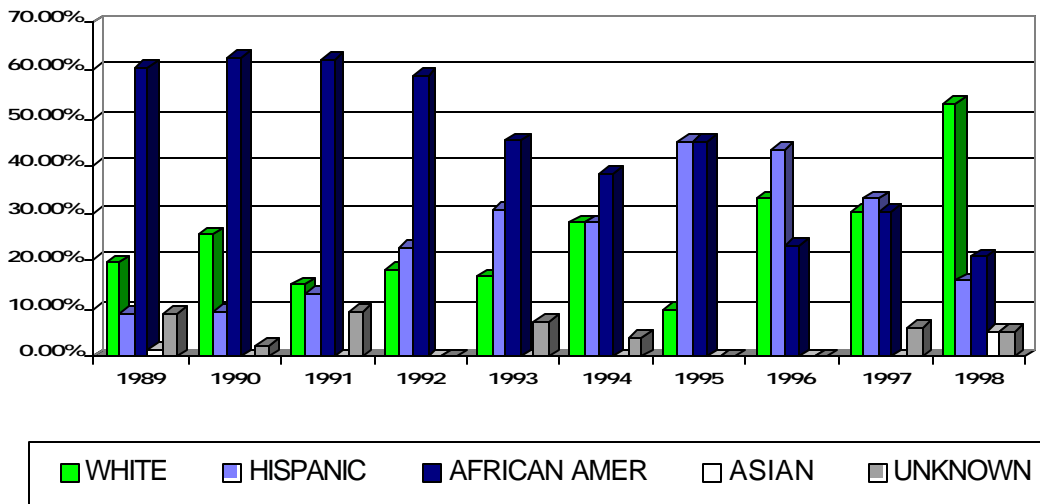
FETAL DEATHS

Asian family. Both of these deaths involved maternal substance abuse. In two of the fetal death cases, the ethnicity was unknown. Figure 21 shows the comparative rates of fetal deaths among the different ethnicities.

**Table 23**  
**ICAN 1998 FETAL DEATHS BY ETHNICITY AND MANNER OF DEATH**

	AFRICAN-AMER	HISPANIC	WHITE	ASIAN	UNKNOWN	TOTAL
Accident	4	17	7	2	0	30
Undetermined	1	2	1	0	2	6
Homicide	1	1	0	0	0	2
<b>TOTAL</b>	<b>6</b>	<b>20</b>	<b>8</b>	<b>2</b>	<b>2</b>	<b>38</b>

**Figure 23**  
**1988 - 98 FETAL DEATH PERCENTAGES BY ETHNICITY**





**DEPARTMENT OF PUBLIC SOCIAL SERVICES INVOLVEMENT**

DPSS records revealed that 26% (n=10) of the families had a record of receiving public assistance. It is known that there were siblings present on 7 of the 10 DPSS cases. In addition to the 4 cases with a DPSS record already open to DCFS, a referral was made to DCFS following the fetal death on 2 additional cases with a record of DPSS involvement. The other 4 cases with DPSS involvement had no record with DCFS.

**CRIMINAL JUSTICE SYSTEM INVOLVEMENT**

Eight law enforcement agencies were involved in the investigations of the fetal deaths in 1998. 6 of the case investigations involved the Los Angeles Sheriff's Department and 18 of the case investigations involved the Los Angeles Police Department. Six additional police agencies were involved in 14 of the fetal death investigations. Table 24 shows the law enforcement agencies involved in all fetal deaths reported to the Team for 1998. Division area detail is reported for the Los Angeles Police Department.

Two of the fetal deaths were presented to the District Attorney's Office for consideration of filing criminal charges. One of these cases involved maternal drug usage, but the case was rejected by the District Attorney's Office due to insufficient evidence. In the other case, a maternal assault case, the District Attorney's Office filed murder charges against the mother's boyfriend for the murder of the mother and her fetus. The disposition on this case is unknown. On two additional cases, charges are pending. In one case, a maternal substance abuse case, the mother was arrested for violation of her parole. In the other case, a maternal

assault case, law enforcement believes that the mother and her fetus were killed by the mother's boyfriend. However, there is currently insufficient evidence to present the case to the District Attorney's Office for the filing of criminal charges. The investigation remains open.

**Table 24  
LAW ENFORCEMENT AGENCY INVOLVEMENT IN 1998 FETAL DEATHS**

<b>LAPD</b>	<b>15</b>
Northeast Division	5
Southwest Division	3
Rampart Division	2
Wilshire Division	2
Central Division	1
Devonshire Division	1
Foothill Division	1
Hollenbeck Division	1
Van Nuys	1
77th Division	1
<b>LASD</b>	<b>6</b>
<b>Long Beach P.D.</b>	<b>7</b>
<b>Inglewood P.D.</b>	<b>3</b>
<b>Compton P.D.</b>	<b>1</b>
<b>Monterey Park P.D.</b>	<b>1</b>
<b>Pasadena P.D.</b>	<b>1</b>
<b>Redondo Beach P.D.</b>	<b>1</b>



## INTRODUCTION TO "HOW TO" GUIDE FOR CHILD FATALITY REVIEW TEAMS

Child Fatality Review Teams play a critical role in defining the underlying nature and scope of fatalities from child abuse and neglect. Many benefits result from the work of Child Fatality Review Teams, including identifying gaps and breakdowns in agencies and systems designed to protect children, more effective determination of the cause of suspicious deaths, and accurate identification of deaths due to maltreatment. The Teams also provide an opportunity to identify factors that increase the likelihood of serious and fatal child abuse as well as preventable deaths from accidents, disease and suicide.

California formed the nation's first Child Fatality Review Team in 1978. There are now Child Fatality Review Teams in all 50 states, as well as in Canada and Australia. The following "How To" Guide for Child Fatality Review Teams was developed as a part of the curriculum for the ICAN California Child Fatality Training Project. This Training Project, conducted under the auspices of the Office of Criminal Justice Planning and the California Department of Social Services, Office of Child Abuse Prevention, is designed to provide a core training program for professionals interested in the Child Fatality Review Process. To date, 6 on-site Regional Training Sessions and a National Satellite Training Broadcast have been completed and more on-site Regional Training Sessions are anticipated for the coming year.

The "How To" Guide is presented here

to provide guidance on the basic structure and functioning of a Child Death Review Team and to provide the reader with a basic understanding of the Child Fatality Review Process.



## "HOW TO" GUIDE FOR CHILD FATALITY REVIEW TEAMS

This "how to" guide includes the basic lessons for building, rebuilding, maintaining, and increasing the effectiveness of the multi-agency system commonly known as the "Child Fatality Review Team." This manual is based on the experience and publications of hundreds of teams in the United States, Canada and Australia. The preventable death of any child is a tragedy. It may also be an opportunity for a community to grow together, learn together and thereby grow stronger.

### **Case One**

A three year old is beaten to death by his father. Three years later, after a review of old cases, the original mode of accidental death listed in this case is changed to homicide and the father is sent to prison. Five siblings, who were seen by Fire Department Emergency Medical Technicians at the death scene, were not noted in any other agency record. These sibling survivors of fatal child abuse apparently were never interviewed and a very delayed attempt to find them determined only that they had moved and could not be found.

### **Case Two**

An emaciated infant dies after a series of beatings while in the care of her mother and her mother's male companion. The District Attorney does not file charges because there is not enough evidence to prove "beyond a reasonable doubt" that one or the other parent caused the death. There are also no misdemeanor charges filed and none of the agencies involved with the fam-

ily reports the case to the state Child Abuse Index. Agencies who may have future contact with these adults will probably find no record of this cruel infanticide.

### **Case Three**

A single family has had multiple agency contacts: a public health nurse has been following a "failure to thrive infant;" a child protective services worker has evaluated a toddler who may have been molested; two separate hospitals had seen both these children who had been brought in by their mother in the early AM with vague complaints about possible injuries; the police and fire EMT have been called to the family's home several times for domestic violence; several years ago another child in the family died from "undetermined" causes. None of the professionals involved in any one of these events knew of the actions of the professionals involved in any of the other events.

### **Case Four**

A teenager with a history of having been sexually abused as a child is found dead from a self-inflicted gun shot wound. This teenager had been having school problems and had a history of acting out in class. The teenager had also been to the hospital several times for treatment of various injuries, including an overdose of drugs. Previous interventions may have been sufficient enough to stop the molestation but did not address other factors and were not adequate enough to provide the child with a healthy environment.

be more effective in addressing the many issues involved in child deaths. As a result of team review, agencies may change official protocols and policies, particularly as they relate to multi-agency intervention.

3. When professionals and agencies are connected in a collaborative way, they can then build a more open system of multi-agency cooperation and can form alliances that address possible fatal and severe child abuse/neglect.
4. Child Fatality Review Teams have shown that it is possible to continue past the "child abuse deaths" to address other non-fatal family violence and many other forms of preventable "accidental" and "natural" deaths.
5. Teams that are working together on issues pertaining to child death also learn how to develop a multi-agency focus on infants, toddlers and high-risk pregnancies, which can lead to the development of prevention and early intervention programs.
6. Team reports that address child deaths and highlight recommendations aimed at prevention can be shared across state and national boundaries and can provide a tool for the sharing of information and resources.
7. Neighboring Teams can visit each other and share resources. They may also want to join together to form a Regional Team Review process.
8. State Teams can provide a forum for the sharing of resources and can support local data collection for use in the development of state mandates and state reports.
9. Over time, Teams can expand to engage in a retrospective review of old cases, which will be augmented by the knowledge and experience gained from earlier

team reviews.

10. The national interaction of State Teams, National Associations and Federal Agencies can provide a forum for the development of a national system for the Child Fatality Review Process. International contacts can provide the resources to coordinate this process on an international basis.

### **III. Basic Team Structure, Philosophy and Process**

Almost all active teams have developed a similar structure of membership, philosophy, and case selection.

#### **A. Core Membership**

1. Coroner/Medical Examiner: Responsible for providing critical information on the manner and cause of death for all unexpected and/or unexplained child deaths including trauma deaths such as homicides, suicides, and accidents.
2. Law Enforcement: Responsible for investigating potential suspicious deaths.
3. Prosecuting Attorneys: Responsible for prosecuting provable criminal deaths.
4. Child Protective Services: Responsible for intervention with familial child abuse/neglect.
5. Health (the most varied of the Core Team Members): Responsible for providing evaluation and treatment to injured children, reporting suspected child abuse/neglect, engaging in outreach to children at risk of abuse/neglect through public health nursing programs, and keeping vital records of births and deaths.

Most teams grow with time to include others including: Juvenile or Civil Court attorneys, representatives from schools, mental health departments, probation departments, fire emergency technicians (EMT), clergy, child life specialists and child advocates.

both easier to do and more complex in scope. For instance, death data may be mixed with other population data to analyze the rates and distinctions between the prevalence and the incidence of death.

#### **D. Systematic County Level Demographic Data Set**

A third level of data collection includes a systematic collection of demographic data, that looks for patterns and problems which can be addressed by changes in programs, policies or laws. This data collection level is visible in the growing number of states and/or counties that issue written reports on various types of child deaths within that county.

#### **E. County/State/National Triple Data Set**

A further layer of data collection involves the integration of state data bases with local case data. This "triple data base" model involves reconciling local case data with data from the following three state/national level data sets:

1. Law enforcement child homicides recorded in the Federal Bureau of Investigation - Uniform Crime Reports - Supplemental Homicide Reports (FBI-UCR-SHR). These are "child homicides" as determined by law enforcement.
2. Vital statistics child homicides as recorded in vital statistics kept by public health agencies, typically through death certificates. These are those child deaths that a Coroner determines fits the "homicide" mode of death.
3. "Fatal child abuse/neglect" as noted in state Child Abuse Central Indices. These are deaths due to child abuse or neglect which are reported to the state index by law enforcement and/or child protective services.

Through this reconciliation process lost cases and case information can be identified. In California, local and state efforts to

reconcile these various data sets has resulted in the discovery of cases and case information that had been lost due to the failure to properly complete forms or input collected data. In addition, this reconciliation process can help to find cases that have been lost to multi-agency intervention because information was not shared across agency lines. Multi-county cases also may be identified through this reconciliation process, thereby assisting case managers in finding their counterparts in other counties. Finally, the reconciliation process provides for a method of quality control and a common language. This is necessary to build a foundation for a statewide data information system that will be able to methodically and predictably examine fatal child abuse/neglect.

### **VI. Common Problems/Answers**

#### **A. One Agency Won't Cooperate**

This is a fairly common problem and is often addressed by the rest of the agencies continuing to review cases as well as they can, while noting the absence of the single member. With encouragement, the reluctant agency may return in a month or so, or may continue to avoid participation until there is major pressure from other members. Neighboring experts may assist in the encouragement and motivation of their counterparts. The situation may also be resolved if a new source of data is found or a single person leaves or is replaced.

#### **B. Records Can't Be Found**

It may be particularly difficult to find previous health records if there are multiple hospitals or clinics where care was provided. It is also hard to find records from multiple counties and to connect state and county record systems. As teams grow, they tend to pursue more information and are able to search with more accuracy. A team might

### **I. Senior Administrators or Political Leaders Are Bothered By Negative Statements in Reports about Child Death**

All systems have failures and successes. It should be possible to write a report that is objective and speaks of the shortcomings and strengths of all members. The fact of continued child death makes it impossible to maintain accurate and consistent data and also write a report that includes improvements and remains only positive.

### **VII. Extensions of Process**

#### **A. Domestic Violence Fatality Review**

Numerous counties and states have begun a systematic review of fatal domestic violence. This review process may be an extension of the local team, particularly in smaller counties, or may be a new team of professionals brought together specifically for this purpose. A national network is beginning to form and coordinate with child fatality review and there should be a national presence for domestic violence fatality review in a few years.

#### **B. Review of Non-Fatal Severe Child Abuse/Neglect**

Children should not have to die to merit systematic attention. In some states or counties, hospitals are beginning to extend their multi-disciplinary teams to address a multi-agency review of children hospitalized with severe injuries.

#### **C. FIMR and SIDS Programs**

The United States Department of Health and Human Services (USDHHS) sponsored a meeting in November 1997, with professionals involved in Child Fatality Review (CFR), Fetal Infant Mortality Review (FIMR) and Sudden Infant Death Syndrome (SIDS). This group recommended that CFR and FIMR should work together on data collection, noting that CFR and FIMR have a parallel process for gathering data. In addition,

SIDS programs have a service component that we can all learn from in our treatment of surviving siblings and other family members.

#### **D. Multi-County and Multi-State Case Review**

This pattern of review is already underway as counties find components of their cases in other counties, often because of injured children being brought to neighboring medical facilities or families traveling to other counties or states. The national directories of teams compiled by ICAN/NCFR facilitates referrals to distant states. The fact that some family problems naturally cross state lines will force us to learn how to share information and resources across these state lines.

#### **E. Computers, E-mail and the World Wide Web/ A National System for Child Fatality Review**

The rapid growth in the use of computers and the Internet is also driving changes in child fatality review. More teams are using computers for word processing and, with time, will use them for data collection, data analysis, and composition of reports. The Internet and E-mail are also making it possible to find others in different Regions and to search for information on multiple topics. ICAN/NCFR sponsors a web site ([ican-nchr.org](http://ican-nchr.org)) and ListServ. Multiple states are now posting team reports on their web sites. A national data system has been proposed matching national data sets on child death.

#### **F. Prevention Program Addressing Perinatal and Infant Toddler Issues**

The child fatality review process increases individual agency competence for interventions with infants, toddlers and women with high risk pregnancies. The multi-agency team learns the value of sharing resources for intervention before any injury or death occurs.

### **IX. Prevention / Health**

Child Fatality Review helps identify high risk behaviors and other factors that can assist professionals in preventing future deaths. The findings of Child Fatality Review Teams may assist prevention focused programs, such as home visiting and parenting education, in strengthening their programs. Child Fatality Review also functions in a preventive way by assuring that surviving siblings are not placed in harm's way, and that adults who are violent towards children are monitored as to their future associations with children. While Child Fatality Review Teams often have a primary goal of working to prevent child abuse fatalities, the larger effect from a county team is the potential to develop prevention efforts for all causes of deaths including accidental, natural and/or non-intentional deaths.

Campaigns and programs addressing child deaths which value prevention include:

1. Public education on the potential hazard of accessible 5 gallon buckets to young toddlers resulting in toddler drownings.
2. Infant automobile safety seat campaigns that provide donated seats for families who have limited funds.
3. Child-proof drug containers, particularly for prescription pills or iron pills that resemble candy.
4. Traffic safety campaigns and the provision of speed bumps in neighborhoods with large numbers of young children.
5. The enacting of ordinances for four-sided fencing to help prevent pool and spa drownings and river safety programs that utilize warning signs in multiple languages.
6. The provision of smoke detectors for sub-standard homes (particularly homes where infants and toddlers reside) by child protective service agencies.
7. More intensive evaluations for home safety through the use of multi-agency records.
8. An increased awareness of the needs of infants and toddlers by both law enforcement and child protective services.
9. Multi-agency joint home visits by public health nurses, child protective services and law enforcement.
10. Perinatal intervention programs for women in jails and juvenile facilities.
11. Parenting programs for incarcerated parents, particularly young fathers.
12. Multi-agency integrated data systems to coordinate and monitor services to children and families with multiple problems.



**Expert Witness** - someone the court determines to have expertise on a subject (does not necessarily require any graduate degree)

**Family Court** - court designated to hear matters pertaining to family law (e.g. divorce and child custody)

**Fatality** - loss of life (see death)

**Fetal Death** - (common) death of pregnancy after approximately 20 weeks

**Fetal Death Certificate** - official document noting the death of a fetus (note - does not include a space for mode of death, see mode of death)

**Fetal Homicide** - (law) the death of a viable fetus caused by competent intent (see viable fetus)

**Forensic** - having to do with the study of criminal acts

**Forensic Pathologist** - a pathologist with training in criminal pathology (see board certified)

**Foster Care** - placement for children under dependency court jurisdiction (note- this includes single family homes, group homes with no more than six children, or institutions with many children -see dependency court)

**Homicide-** (official) death caused by another with the intent to kill or severely injure

**Homicide** -(common but not official) death at the hands of another (without reference to intent)

**Homicide Detective/Investigator** - a police department or sheriff department investigator with an expertise in homicide investigations

**Injury** - caused by physical trauma

**Infant** - child under one year of age (see neonate)

**Intentional Injury** Death- public health term used to define death caused by another with the intent to cause harm (see competent intent)

**Intern** - post student trainee (e.g. a physician's first year of work after medical school)

**Intent** -desire to cause to happen (see competent intent)

**ListServ** - computerized newsletter that allows individuals to share information with a group

**Mechanism of Death** - the physical reason for a death (e.g. head trauma caused brain swelling which caused decreased brain function which caused the heart and/or lungs to stop functioning)

**Mode or Manner of Death** - official category for a death certificate (homicide, suicide, undetermined, accidental, natural)

**Neonate** - infant under one month of age